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ABSTRACT

This booklet describes a framework for helping preservice teachers learn and implement behavioral intervention strategies in inclusive classrooms. A partnership of Human Services Consultants and Bloomsburg University taught 19 preservice early childhood and elementary teachers behavioral intervention strategies for mainstreamed students with severe behavior disorders. During week 1, students received orientation, completed a pretest survey, toured buildings and facilities, discussed agency and district policies and rules, received information about target students, and established visitation and conference times. During weeks 2-13, students received one-to-one and/or group support and intervention including behavior modification techniques and proactive strategies to stabilize pupils. They worked collaboratively with the team, developed schedules, and received training. The training focused on behavior management interventions; basic behavior techniques (teamwork, diversity, and ethics); identifying challenging students; teaching social skills; developing self-esteem; helping children handle anger; and meeting student needs in inclusive classrooms. The project produced a manual, a consultant bank of resources, a vehicle for collaboration, and professional development among preservice teachers, inservice teachers, behavioral specialists, and university faculty. This booklet offers training session summaries, behavioral support project sample case studies, and reflections from participants. Nine appendixes include program evaluation; student teacher pretest and posttest questionnaires; behavioral support content-specific questionnaire; oral debriefing report; Behavioral Support Internship syllabus; internship time sheet; release form; and resources. (SM)

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The Behavioral Support Project:

Skillstreaming Through Collaboration

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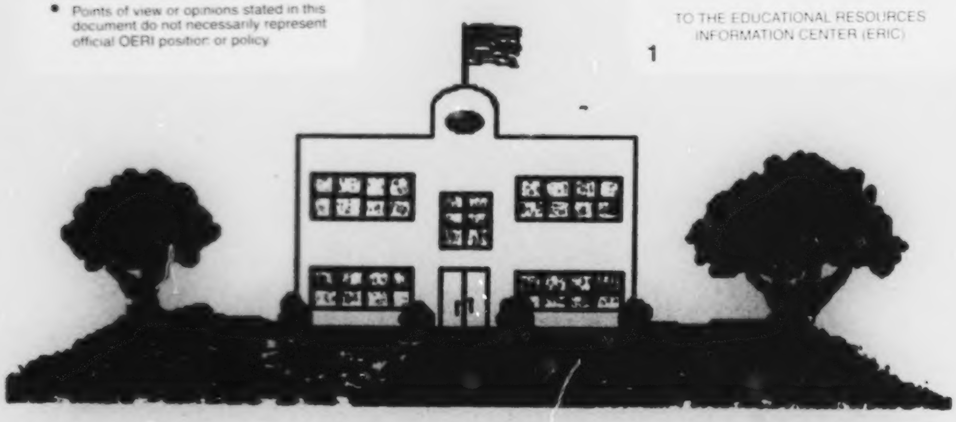

Partners:

Bloomsburg University
and
Human Services Consultants

SP037740

The Behavioral Support Project

A Compilation on
Implementing A Behavioral Support Partnership

Project Members:

Dr. Viola Supon
Dr. Bonnie Williams
Dr. Robert Clarke
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A Partnership with Bloomsburg University
and
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Bloomsburg, Pennsylvania 17815

December, 1997

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The Behavioral Support Project: Skillstreaming Through Collaboration

by:

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ABSTRACT

This compilation provides a program framework for having pre-service teachers learn and implement behavioral intervention strategies in inclusive classrooms. Through a partnership with a community agency, university students (interns) acquired competencies from therapeutic support staff, district teachers, and university faculty. The program's design, activities, implementation time line, and evaluation procedures are included. Contained herein are various summaries of professional training sessions, sample case studies, goal sheets, review of related literature, interns' self-reflections, course syllabus, program evaluation, oral debriefing report, and an extensive bibliography.

Acknowledgments

This compilation is the result of the collaboration and efforts of many individuals. A colossal thank-you to the Higher Education Initiative for the funds provided for this innovative project. The contributions generated rich and educationally rewarding dimensions for many people involved with this endeavor. To Human Services Consultants, a huge thank-you for providing the expertise to this partnership. Richard Adams, (Chief Executive Officer), Marie Craven (Director of Programs), Diane Lueb-Matthews (Clinical Director), along with their staff, professional speakers, and therapeutic staff provided competent direction. Kudos to all at HSC for allowing our interns to pursue the program's objectives. We are very grateful for the commitment and professionalism exhibited by HSC personnel throughout this project.

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The interns who made the project work deserve special plaudits. Their hard work and dedication made this endeavor successful and meaningful.

As a final note, we would like to express our sincerest gratitude to the teachers and administrators in the various school districts where our interns were placed.

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I. Introduction:

A. Statement of Purpose:

Through the partnership of Human Services Consultants and Bloomsburg University, preservice teachers became skilled in behavioral intervention strategies to meet the needs of children with severe behavioral disorders. With the guidance of trained behavioral specialists and therapeutic staff, 19 preservice teachers enrolled in early childhood and elementary programs learned and implemented effective behavioral intervention strategies in inclusive classrooms. This project produced a manual, a consultant bank of resources, a vehicle for collaboration, and professional development among preservice teachers, inservice teachers, behavioral specialists, and university faculty.

B. Rationale:

As a result of the current educational thrust to make all schools and classrooms inclusive, preschool and elementary education teachers are faced with the challenge of teaching children with varying disabilities--such as behavioral disorders. In fact, students with behavioral disorders may be the biggest challenge to any effort for total inclusion (Whitaker and Votell, 1995).

According to Kauffman, et al. (1995, p. 543), many teachers are not prepared to "teach and manage" in order to meet the needs of all children--particularly those with behavioral difficulties. Educational studies report that very significant changes must occur in what teachers know and do before a majority of regular classroom teachers are skilled to create the minimum opportunities necessary for the success of students with behavioral difficulties while also delivering an appropriate program for other students (Lloyd and Kauffman, 1995). Other experts believe the ultimate success or failure of inclusion rests on the ability and willingness of the classroom teacher to put it into practice (Greer & Greer, 1995).

Another critical issue is that "many students with serious behavior disorders remain in regular classes and receive little or no special help of any kind" (Kauffman, et al., 1995, p. 543). According to Albert Shanker, President of the American Federation of Teachers, successful implementation of inclusion practices will occur only if they provide teachers with help such as support personnel, released time, and ongoing training (Long, 1995). Other educators suggest that for inclusion to work, it will require a partnership between the regular classroom teacher and other specialized personnel who will need to work with these children. Such a collaborative effort will help to ensure the delivery of a comprehensive education system that has the potential to meet the needs of all students (Whitaker and Votel, 1995; Forest, 1987; Stainback & Stainback, 1984; Gartner & Lipskey, 1987).

Marie Craven, Director of Program Services, has indicated that there has been an enormous growth in the number of children (with behavioral difficulties) needing to be served in the school systems in Luzerne and Columbia counties of Pennsylvania. This has placed burdens on teachers, schools, behavioral support personnel, and communities within these parameters. School districts within these areas have contacted Human Services Consultants in Kingston, Pennsylvania in order to get support services for the children with behavior disorders. These services include behavior therapy and therapeutic staff support.

The role of the Human Services Consultants agency was to provide the necessary behavioral support expertise that is limited in Bloomsburg University's regular program for training elementary and early childhood teachers. Specifically, the agency provided 10 behavioral support specialists who trained 19 Bloomsburg University preservice teachers. This is an appropriate role, as the agency can provide opportunities for Bloomsburg University's preservice teachers to directly interact with identified students. These opportunities provided actual intervention experiences in inclusive classroom.

The faculty of Bloomsburg University's early childhood and elementary education program has recognized the need to assist its preservice teachers with the necessary skills to assist them in meeting the challenges they face with children exhibiting severe behavior difficulties in inclusive classrooms. However, the design of the regular teacher preparation program does not typically address the unique aspects of behavioral interventions for the non-compliant student and offers few opportunities to interact with exceptional children.

The Behavioral Support (B.S.) Project functioned as an Internship in Education (79.312) for 3 credits. As stipulated in "Bloomsburg University Internship Guidelines," student are required to log 40 hours per credit in the field. Due to the nature of this project, the 120 hours consisted of 90 hours working in the field with the behavioral specialist, the identified student, and the classroom teacher and 30 hours participating in seminars and training sessions.

C. Goals:

1. To increase collaboration among preservice teachers, inservice teachers, and behavioral specialists when working with children with behavioral disorder in inclusive classrooms.
2. To prepare preservice teachers in the theory and application of behavioral intervention and support strategies under the guidance of certified behavioral specialists and a clinical psychologist.
3. To produce a manual of effective behavioral intervention strategies that can be used by preservice teachers, inservice teachers, behavioral specialists, university faculty, and other interested professionals.
4. To develop a consultant bank of resources.
5. To provide professional development for preservice/inservice teachers, behavioral specialists, and university faculty.

D. Expected Outcomes:

Anticipated outcomes for this project included increased collaboration for preservice teachers inservice teachers, behavioral specialists, and university faculty in planning and working with students with behavioral disorders in inclusive classrooms. The preservice individuals had the opportunity to experience training in the theory and application of behavioral and support intervention strategies. This project will produced a manual of effective behavioral intervention strategies that can be used by preservice teachers, inservice teachers, behavioral specialist, and university faculty.

E. Evaluation Activities:

Evaluation activities included: pre and post project participant questionnaire, assessment of the individual interns by the designated behavioral therapeutic support and university faculty, self reports by each intern,, a categorical analysis of each intern's activity log, an oral debriefing of each intern based on observation notes and group processes, and a written manual reporting the complete findings regarding the project and the participants' recommendations for future training (meta-analysis).

F. Activities and Implementation Timeline:

The following projected student activities were implemented each semester with a cluster of seven university students participating one semester and twelve students the second semester.

Week One

Orientation; completed questionnaire as a pretest measure; tour of building and facilities, discussion of agencies'/school districts' policies, rules and expectations, information about identified children, establish visitation and conference times.

Weeks Two-Thirteen

Began assignments by providing 1:1 and/or group support and intervention including behavior modification techniques and proactive strategies to stabilize the child or adolescent; worked collaboratively with the behavioral specialist and team members; developed and maintained a flexible schedule, participated in inservice training, seminars, and self education. Training sessions were conducted at the Human Services Consultants' facility. Training sessions were conducted by the Behavioral Support Staff and invited consultant speakers. Attended seven 2-hour seminars conducted by Bloomsburg University project professors in the evening. Students maintained a log of behavioral progress and relayed information to team members, supervisors, and behavioral staff.

Week Fourteen

Completed post-test and self-report, analyzed areas of growth, insights gained, perceptions, and future goals, debriefing, University Project Co-Directors' Evaluations and Behavioral Support Staff assessment of university students' progress and performance. Repeated activities and timeline for second semester with a different group of preservice teachers. The meta-analysis occurred between the two semesters and at the conclusion of the second semester. From the latter part of May through October, the compilation and printing of the manual occurred along with the professional development activities.

II. Behavioral Support Training Sessions:

A. Human Services Consultants Training Sessions -

Managing Behavioral Interventions - Part I

Focused on Behavior Treatment Plans and The Basic Model - History, Model, Intake, Matching Treatment with Children.
Trainer: Dr. Mary Fitzpatrick
Director Cognitive Behavior Therapy Unit
Cornell University Medical College
New York, New York

Managing Behavioral Interventions - Part II

Focused on Behavior Management, Anger Control, Anxiety Phobias and specific problem areas such as toileting and sleep disturbance.
Trainer: Dr. Mary Fitzpatrick

Managing Behavioral Interventions - Part III

Focused on small group activities and problem solving sessions based on participants needs.
Trainer: Dr. Mary Fitzpatrick

Managing Behavioral Interventions - Part IV
Focused on small group activities and problem solving sessions based on participants needs.
Trainer: Dr. Mary Fitzpatrick

Basic Behavior Techniques:
Trainer: Dr. John McElwee

Session #1 -	Working as a Multi Team Member - An Introduction
Session #2 -	Working as a Multi Disciplinary Team Member - Skills and Strategies Associated with Working with Involuntary Families.
Session #1 -	Applied Behavior Shaping Techniques for Therapeutic Staff Support Cultural Diversity - Beginning Skills of Culturally Competent Practices and Assessment.
Session #2 -	Applied Behavior Shaping Techniques for Therapeutic Staff Support.
Ethics -	Professional Code of Ethics and Human Services Consultants Policy on Ethics. How to Recognize an Ethical Dilemma, Guidelines for Ethical Decision Making.

B. Bloomsburg University Seminar Topics:

Identifying Characteristics of Children with Challenging Behavior
"Help This Kid is Driving Me Crazy"
Intervention Strategies That Work
The Importance of Teaching Social Skills
Integrating Manipulatives and Varied Resources for Children with ADHD
Recognizing the Emotional Curriculum
Discovering Children's Literature That Recognizes Disabilities
Developing Self-Esteem
Helping Children Deal with Anger
Effective Strategies for Meeting the Needs of Children with Disabilities in the Inclusionary Classrooms

III. Selected Training Session Summaries:

Working as a Multidisciplinary Team Member - by Susan Aiken

The seminar commenced with the presenters, Dr. Joanne Whelley, Helen Mericle, and Mark Malkemes, discussing the goals of the seminar. These goals consisted of improving communication, improving team work, and coordination of services while understanding the responsibilities and the role of a team member. To accomplish these goals, the members of the team explained their own belief systems as team members and how that related to the content of the seminar.

They defined team as a number of people who work together on a specific task. They related that team building isn't a new idea, but is a concept reborn. One of the benefits of a team approach is an accelerated completion of a complex task. As in any relationship, differences will occur. In teams, conflict may occur more often because there are usually more than two people involved. Too often, when differences occur in team meetings, they are simply smoothed over by the leader or other members. In these cases the conflict doesn't go away; it just simmers until a later date. The only thing accomplished is the gradual building up of resentment between the members. Because managing conflict is a necessary part of team building, you need to consider the relationship between team building and conflict.

There are two possible ways to make decisions as a team, voting or consensus. Although voting is quicker, it can help promote division within the team. When there is a vote on decisions, there are winners and losers. In teams, the idea is for everyone to agree on the decision. Reaching consensus is more difficult than voting, but it is the preferred approach to team-building decisions. It does take longer and differences will occur in the process; but in the end, everyone supports the final decision. This is important to the teams with whom the TSS' work. Parents and children (or clients) are members of those teams. For solutions to be effective and complied with, both of these members must be in agreement. It would do no good for the rest of the team to agree that something is best (even though it may be) for a family without that family supporting that decision. They need the cooperation of the child and the parent to implement any changes or solutions.

We explored the problems of being a team member. We agreed that for most of us, being a member of a team is not always easy, especially if we are accustomed to making decisions on our own. When you become a team player, you enter into an interdependent relationship. You may even feel you are giving up your individuality. But in another sense you are making an individual contribution to a group effort that usually produces a greater end result than you could have achieved on your own.

We identified our own personal style as a team player by completing a Team Player Profile Survey. These styles consisted of contributor, collaborator, communicator, and challenger. We discussed the characteristics of each style and polled the group to determine the group dynamics.

Some of the professional barriers to effective teamwork are educational preparation of team members, role ambiguity and incongruent expectations, status differentials, authority and power structures, and leadership styles. One barrier that seemed to be problematic for the TSS workers was personal defensiveness. We learned that the key factors in team development are: commitment, trust, purpose, communication, involvement, and process orientation. If these aspect of team building are emphasized for the team, most of the barriers can be overcome or avoided completely. If these areas are defined and emphasized for the team members, many problems can be avoided.

We also talked about empowerment and how we can empower the people we work with. Some of the suggestions offered were: 1) give them important work to do, 2) grant them choices in doing their work, 3) give them the resources to do their work, 4) give them praise and recognition, 5) make them feel their survival is in their own hands, 6) enhance and build task skills, 7) encourage them to work in teams, and 8) welcome surprise which makes someone feel more trustworthy.

We ended the session by taking a case study and developing ways to work as team members to help empower the client and each other while solving the problem.

Identifying Characteristics of Children with Challenging Disorders - by J. Rebecca Howell

This seminar began by having interns share their experiences. We were fortunate enough to have four interns out in the field by this meeting and they were more than willing to share their experiences with us. Kurt started out. He spoke about how he will be working with a little girl and what her behavioral problems are. What I think was most notable was his statement: "Never let your eyes off of them for a minute." I hear that all of the time but usually never pay any attention to it, but, when he went into what she did when his back was turned, that made me realize that I will be working with a child who has a behavioral problem and that new measures will be needed to be enforced to deal with the different situations. Jen and Sariann are both working with the same boy so it will be interesting to hear their different points of view. Allison spoke of her child being very much out of control and how she bit the TSS and caused much of a disturbance. This initial sharing was very beneficial to all of us who had not yet ventured out. We all had an idea of what to expect now.

After the sharing the experiences, we examined the characteristics of children with behavioral problems. The characteristics we discussed were: attention deficit, seeking attention, home environment (abuse, neglect, poverty, violence, drugs and alcohol, and nutrition), excessive behavior, non-compliance, anti-social behavior, poor academic achievement, aggressive, rebellious, low self esteem, and depression. We discussed each characteristic and came to the conclusion that all behaviors are learned.

We watched a video that was divided into two parts. The first part dealt with ways a behaviorally challenged child can act. It stated that the child gets very excited when new things arise. The child can get loud, laugh out of control, cry excessively, or even run around. The child's play will also be different. The behavioral problem child will get bored very easily and then want something new to do. The child will always be moving and will tire you out quickly. The child's social skills are also different. This type of child will hit or shove and wants control of everything. The child will not adapt to change easily and will need the parents' attention all of the time. Such a childr will not understand "no" and demands things. The attention span is also very low. We discussed these aspects and decided that not all of these need to be present to know that a child has a problem.

The second half of the film spoke of things you could do to help the child. It listed six things: 1) keep yourself under control; 2) look for good; 3) redirect the child's behavior; 4) structure the child's environment and activities; 5) help the child develop language skills; 6) and schedule time for yourself. We then discussed all of these and the importance of each one.

I would have to say our first seminar was a success. Being able to talk freely in a room with all of the people knowing and relating to what you are talking about was very reassuring. After this seminar, I was very much looking forward to my first day in the schools.

Basic Behavior Techniques - by Sariann Knerr

Dr. John McElwee provided the group with a brief history on autism and early intervention programs. Human Services Consultants (HSC) calls its program the Discrete Trial Training Program. HSC does not provide a 40-hour-a-week service but 10 to 20 hours to augment placement. The staff provides manpower to help execute an intensive program.

We watched segments of a video, Let Me Hear Your Voice, that gave us an insight into Dr. Lovaas' work with autistic children. The video focused on misconceptions, reinforcement techniques, and stimulus-control. In between the sections of the video, Dr. McElwee provided us with additional information on autism.

In a discrete trial program, there are three important components that should be included: stimulus (instruction) from the trainer, a response from the child, and a consequence from the trainer ("good job" or "no"). All three can be used in most behavioral programs, not just with autistic children. The curriculum should include drills or therapeutic activities, including observation, imitation, and social learning. These drills are the behavioral objectives. Good behavioral objectives have criterion levels to determine if the goal was reached with the child, conditions under which the behavior should occur, and the performance of the child (what he or she did).

The next part of the video focused on trials and reinforcement. Dr. McElwee explained that a reinforcer increases behavior to get an effect and to change behavior. It's not a static process but a dynamic one and may not work all the time. The three types of reinforcers are edible, social, and sensory. For maximum effect, they should be delivered immediately. Another type is a negative reinforcer. This is not a punishment because it strengthens a response through the removal of an unpleasant stimulus. It's important to remember that reinforcers should be given intermittently, not continuously, to avoid satiation.

Next, Dr. McElwee discussed shaping, the rewarding of successive approximations of the target or final response. This is a very powerful technique and is used all the time in discrete trials. The one disadvantage to shaping is that the trainer must wait until the child responds. One way to avoid this situation is by prompting or guiding the child to get a quicker response. We saw on the video that Dr. Lovaas used imitation tasks or drills as prompts to get the child to name objects. Dr. McElwee then explained that autistic children tend to become dependent on prompts so fading, or the gradual removal of the prompts, is necessary.

When working with autistic children, the trainer should break down the behavioral objectives into manageable units (a behavioral chain of stimuli and responses). Two chains can be used: forward chains, which are taught from the first step to the last step; and backward chains, which are taught from the last step to the first. However, the most powerful technique to use every time to teach a behavior is shaping, followed by fading.

Dr. McElwee concluded the seminar with some common misconceptions about reinforcement. The first is that reinforcement is bribery. As he explained it, bribery is an incentive to do something that is wrong, but rewards are for something positive. Another misunderstanding about reinforcement is that children become dependent on the rewards. While we don't want the behavior to become dependent on the reward, reinforcers are used frequently in everyone's life (grades, money). Finally, some believe that the use of rewards coerces behavior. However, discrete trials are not using adversive events but positive ones. Dr. McElwee pointed out that we have seen through the evolutionary process that rewarding is the only way to teach a skill. As learning creatures, we realize that by avoiding the bad, we will be compensated for the good.

Effective Strategies for Meeting the Needs of Children with Disabilities in the Inclusionary Classroom - by Kerry Hayes

Mary Jones is an expert in learning disabilities. She has a Master's Degree in Learning Disabilities and a minor in Special Education. She is currently working in the Danville Elementary School District on the inclusion project. Mrs. Jones was quick to explain that children live up to or down to the labels given to them. For example, if the child is often referred to as a behavior problem, then the child will act the part of a behavior problem. Teachers also influence the labeling of children in that teachers only see the label and not the student. For example, the teacher will not look forward to seeing Billy Smith, the teacher will be expecting a behavior problem.

Mary Jones went on to say that all children need structure, not just those with the problems. She provided us with a packet of information, and one of the inserts included a list strategies to help a student in any circumstance. The management sections suggested the use of classroom rules of positive reinforcement for individual students. It also gave tips for helping students to better organize themselves. The instruction category gave tips for helping students who have problems with participating in class discussions, different learning modalities (such as students needing to see the materials in order to learn) comprehension problems, such as problems with expressing oneself orally, thinking problems, and so on. There were also suggestions as to what to do when students have specific problems with evaluation. One of these suggestions is to allow for more time in testing situations if the student is having problems with time constraints. Mary Jones emphasized the fact that solutions to these problems are often common sense. She also made the point that everyone learns differently and adaptations have to be made in order to help each student's specific need.

Mary Jones also gave some methods for modifying academics, such as reducing the number of problems on a page. This would help the student to not feel so overwhelmed by work that needs to be completed. Highlighting important words or phrases that students are reading can be done. Another suggestion was to include reading aloud or tape record tests for students who have trouble reading. Rewriting directions at the appropriate reading level was also suggested.

One way to prevent behavior problems, according to Mary, is to determine the academic level of students. This will prevent the frustration of not being able to do the work and eliminate the boredom of the work that is too easy. Determining the pattern of social interactions and the ability to stay on task will help the teacher group students appropriately. The teacher should determine the seating of students as well as the pairing of students to complete tasks. Meeting the needs of students as well as keeping students on task, are major concerns. The teacher should use language that is positive and firm and avoid using language that is demeaning or insulting. The teacher also needs to maintain communication with the home.

Mary Jones also stressed the importance of finding reinforcers that work and using a variety of reinforcers. She gave an example of one student who chose his reinforcers and then set goals to reach each of them. He wanted cookies, then to play music, and his ultimate goal to receive a camera. He was able to achieve all of these goals due to the flexibility of the teacher and support of the school.

Mary ended with a quote that really put things in perspective for me and probably the whole group that night. The quote was by Henry Van Dyke, "The woods would be very silent if no birds sang there except those that sang the best."

Attention Deficit Hyperactivity Disorder - by Katie Donlin

At this seminar, a guest speaker talked to us about attention deficit hyperactivity disorder. I found the presentation very informative.

ADHD is a neurological syndrome whose symptoms include impulsivity, distractibility, and hyperactivity. Studies indicate that approximately 3 percent to 5 percent of children in the United States are referred to clinics.

To be considered symptoms of ADHD, the behaviors must initially have been exhibited in early childhood (prior to age 7) and displayed across a variety of settings (school, home, and play). To meet the diagnostic criteria of the American Psychiatric Association, the child must create disturbances for at least six months, during which time at least eight of the following behaviors be exhibited:

1. often fidgets with hands or squirms in seat,
2. has difficulty remaining seated when required to do so,
3. is easily distracted by extraneous stimuli,
4. has difficulty waiting for turns in games or group situations,
5. often blurts out answers to questions before the questions have been completed,
6. has difficulty sustaining attention in tasks or play activities,
7. often shifts from one uncompleted activity to another,
8. often talks excessively.

There is no one definitive diagnostic test for ADHD. The most reliable diagnostic tool is the individual's history as elicited from the child, from the parents, and, very importantly, from teacher reports. Psychological testing can be helpful in determining ADHD diagnosis, but it is not definitive. A careful evaluation of ADHD must take into account other conditions that may look like ADHD, some of which must be tested by a physician to be ruled out.

There are two main classes of medication commonly used in the treatment of ADHD; stimulants and antidepressants. The stimulants dextroamphetamine sulfate (of which Dexedrine is most frequently used) and methylphenidate (trade name: Ritalin) are probably the best-known medications.

To determine the proper dosage, a child's weight and response to medication are taken into account. The smallest dosage possible is administered until a therapeutic level is reached. This level is determined by the child's behavior, as reported by his or her parents and teachers. Parents and educators are also in the best positions to observe how long each dose lasts and to help the doctor determine the best spacing of doses. A typical dose of Ritalin can last from three to six hours, depending on the individual's chemistry.

As a child who has been on medication for several years becomes older and grows larger, he or she will require an increased dosage. Some children may develop a tolerance to one of the stimulant drugs. In such cases, the physician may switch to another drug. The most frequently reported acute side effects of Ritalin and other stimulants are appetite reduction and insomnia.

Medication is not the whole treatment for ADHD. The scope of the disorder means that multiple strategies and interventions across the school and home environments are necessary to allow the child to be successful. It is important for parents of a child with ADHD to receive supportive instruction in behavior management techniques that are designed to enhance the child's attention to household tasks and rules. By the time they reach late adolescence, approximately 63 percent of students with ADHD will have received an average of 16 months of individual psychotherapy. ADHD is not considered to be an emotional disturbance, and parents and educators should not expect counseling alone to alleviate core symptoms.

For successful treatment of ADHD, it is imperative that the teacher understand what ADHD is and know how to work with ADHD children in the classroom. Break down large tasks into small tasks. Teachers are urged to use daily progress reports, repeat directions, write them down, and speak them.

Intervention Strategies that Work - by Cathy Angradi

Today the interns spoke about the experiences they encountered.

One intern said she was nervous about observing in a socially/emotionally disturbed class. Another intern works with a 10 year old girl in a special education class, noting that she was enjoying her experiences and felt like she was learning. Her TSS would use a sticker chart for her student. At the end of the week if the chart was filled, the girl would receive a prize.

Another intern works with an autistic girl in a full inclusion classroom. This child needs to take a break from the class after an hour of work to help her refocus.

Another intern works with an 8 year old girl in a special education class. The girl gets easily frustrated and will run away to chew her fingernails. However, she likes the computer and smiles when she sees things move on the computer.

Dr. Supon suggested that we need to make the invisible visible. When observing a child, look for the patterns in behavior.

Through this internship, we need to gather our own skills and acquire them. Safety is a skill. We should slow the process for children with special needs. It is good to list the order of the day for young children. We also need to maintain our patience. We should use positive reinforcement, not negative. Also, we must give children choices and the ask them if they made the right choice.

We then watched a video "Educating Peter," about a boy in a third grade class who had Down syndrome The video illustrated how the teacher, as well as the children, had to adjust to Peter's presence in their classroom.

Integrating Manipulative and Varied Resources to Children with ADHD - by Patricia Lutz

The focus of the discussion this morning was on Attention Deficit Disorder. We watched two short films. The first, "Harry," was about a young boy who had behavior problems and was mainstreamed into a regular classroom. The film showed with how the classroom teacher and her support staff dealt with the behavior of Harry. The second film was entitled, "ADHD in the Classroom." This film focused on how elementary school teachers can effectively run a classroom that has children with ADHD in it. The film addressed behavior modification and the techniques that can be used to focus the attention of a child diagnosed with ADHD.

For the remainder of the lecture, the audience broke up into groups and were instructed to create a child or adolescent with a behavioral problem. The groups had to create the behavioral problem as well as the history of the problem and general developmental history of the child including pregnancy, birth, early development, family data, relationships with others, and the child's strengths.

After regrouping, the presenter selected some of the cases and did a mock interview with the created child's parents. She focused her attention on the parents perception of the problem. She also encouraged the parent to look for patterns in the child's misbehavior as well as examine when the problem began and how the problem has progressed. Finally, she asked the parents how they dealt with their child's misbehavior.

IV. Behavioral Support Project Sample Case Studies:

Behavioral Support Project
Sample Case Study

7 year old female
Behavioral Concerns: Physically Aggressive Behaviors
Temper Tantrum Behaviors
Limited Attention Span
Noncompliance

BEHAVIORAL HEALTH REHABILITATION SERVICES

Plan of Care

(Name)
(Address)
Wilkes-Barre, PA. 18702

________received Behavioral Health Rehabilitation Services under the auspices of Human Services Consultants in her Wilkes-Barre home during this quarter. Initial referral was made due to the display of physically aggressive behaviors (hitting, punching, scratching, kicking, pulling hair); temper tantrum behaviors (yelling, pounding, refusing to take direction/redirection), limited attention span (inability to attend or focus on activity for short periods of time), and noncompliance to reasonable requests.

Due to Interdisciplinary Team meetings, and consensus of team members, it was recommended that Therapeutic Staff Support provide 1:1 intervention in the ______school, Wilkes-Barre School District.

Human Services Consultants Behavioral Health Rehabilitation Services will:

1. Assess and evaluate the necessity of behavioral programming in the classroom.
2. Continue to implement the ongoing behavioral program.
3. Consistently note progress.
4. Maintain contact with ____, her mother, casemanagement.
5. Attend meetings, when notified, in order to communicate progress/concerns.

Behavioral Specialist (Master's level with documented training and experience in the field of behavior management, and experience in crisis intervention) will communicate with ____, her mother, casemanagement, or Therapeutic Staff Support a minimum of one hour per week (4 units per week, 16 units per month) to ensure the implementation of the behavioral program.

Therapeutic Staff Support (Bachelor's level with one year experience working with children, and one year experience in crisis intervention) will meet with ___, and her teachers a minimum of six hours per day, five days per week (60 units per week, 240 units per month), to implement the behavioral program and to ensure the behavioral needs of ____are met.

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Behavioral Health Rehabilitation Services
Behavioral Program
Wilkes-Barre, PA. 18702

____
____
____

Target Behaviors:

1) Physically Aggressive Behaviors (hitting, pushing, scratching, kicking, pulling hair).
2) Temper Tantrum behaviors (yelling, pounding, refusing to take direction/redirection).
3) Limited attention span (inability to attend or focus on activity for short period of time).
4) Noncompliance to reasonable requests.

Program Goals:

1) __________will refrain from the display of the above named physically aggressive behaviors.
2) __________will decrease the display of temper tantrum behaviors (as noted above).
3) ___________will increase her ability to attend/focus on activities.
4) ___________will increase her ability to comply to reasonable requests.

Positive Approaches/Proactive Strategies:

The following proactive strategies will be addressed and implemented throughout Therapeutic Staff Support scheduled hours.

1) ____________is to be made aware of all activities she will be participating in. Keeping _________informed of activities will remind her of the expected appropriate behaviors and resulting positive outcomes.

2) As __________ participates in preferred activities, Therapeutic Staff Support should emphasize her appropriate behaviors.

3) If ___________ is to participate in a nonpreferred activity, and she displays resistance, the nonpreferred activity should be paired with a strong preferred activity.

4) If __________ initiates any physically aggressive behaviors (as noted) or temper tantrum behaviors (as noted), she is to be redirected to a positive activity.

Contract Terms:

1) __________will be made aware of all contract terms prior to program implementation.

2) ___________will be monitored according to specific intervals determined by baseline activity.

A. Token reinforcement according to specific intervals, will be given for absence of discrete expected behaviors (physically aggressive behaviors, temper tantrum behaviors).

B. Length of intervals will be gradually and systematically increased over time according to performance improvement.

PSYCHOLOGICAL EVALUATION

(Name)
(Address)
Birthdate: 05-23-89
Chronological Age: 7-8
Grade Emotional Support
February 3, 1997

BACKGROUND INFORMATION:

________is a seven year, eight month old white female who is currently involved in Behavioral Health Rehabilitation Services under the auspices of Human Services Consultants.

_______was initially referred by her school due to physically aggressive behaviors such as hitting, punching, scratching, kicking and pulling hair. In addition to temper tantrum behaviors during which she yelled, pounded and refused to take direction or redirection, her limited attention span due to her inability to attend or focus on any activities for any extended period of time and her non-compliant behaviors to any request.

_____is the daughter of _______(3-24-53); Mrs. ____claims that ____father is unknown. Mrs._____does report that _____pregnancy was considered normal. However, she was born three weeks early. According to Mrs. _____during her last trimester of her pregnancy, she was extremely hypertensive. _____was born by way of an emergency C-Section at ____Hospital after she went into fetal distress. She did weigh 8 lbs, 8 ozs at birth. _____was diagnosed as having a heart murmur and respiratory problems at birth which did require the use of oxygen. In addition, her ears were not developed. Right after birth, ____was transported to CMC in Scranton where she remained for three weeks in a Neonatal Care Unit. She did come home on June 7, 1989, which was her original due date. _____did have four heart catherizations due to two holes in her heart. She did have heart surgery to repair one hole. The doctors told her mother that the other hole would close on its own. The surgery took place in the Spring of 1991 at _____in Danville. The mother reports that what was supposed to be a seven day procedure turned into 31 days with _____almost being lost on two different occasions due to a bad infection with both lungs filling with fluid. ____did start walking at the age of 2-1/2; she had started walking before the surgery, but after the surgery had difficulty regaining her walking skills. She was talking in sign language at the age of one. By the time that she was 2-1/2 years of age, she was talking much better. According to Mrs. ___, _____is in a Life Skills class placement at the _____school where she has been for approximatley 3-4 years. She does receive speech 2 times a week and occupational therapy two times per week in that placement. In addition, she has been attending John Heinz where she receives occupational therapy on Tuesdays from 4:00 pm to 5:00 pm and she is on the waiting list for speech therapy. The mother reports that she has been with John Heinz on and off for five years. _____does receive MR services and was initially evaluated at Children's Service Center for Early Intervention when she was eight months old by ______. ______did attend school five days per week in West Pittston from the time that she was eight months old.

MEDICATIONS:

______is currently medicating on a generic thyroid pill; one time per day, five mg; her mother notes that this medication does make her hyper. In addition, ____is medicating on Ritalin, 10 mg in the morning and 10 mg at noon when she is at school. On the weekend, Mrs._____reports that she does stretch out the medications, giving ____her Ritalin four times per day, five mg at each spaced interval.

EVALUATION:

______is a seven year, eight month old, white female, who is quite small for her age. However, her atature is in proportion; she does appear similar in size to a five year old. She does wear her brown hair in a ponytail. However, her mother reports that her hair is long, that it goes to her waist. Throughout the evaluation, ____does play quietly. Within the home setting, Mrs. ____ reports that ___has her days and her moments. Mrs. ____is considering respite services which have been offered on several occasions by the MR Casemanagement. ___wants things her way, or no way. She does have temper tantrums and throws toys and will even put her fist up to people or slap them. There is no screaming or head banging. ___is good by herself. However, when she is with other children, she will push them and she wants to be the Leader, the Boss. ____refuses to eat in school. She has had no naps since she was one or two years old. She does go to bed between 8:00 pm and 9:00 pm at night and sometimes can even stay up until 11:00 pm or 11:30 pm. She does get up between 7:30 am and 7:35 am. ____does like the movies of Whoopie Goldberg, especially Sister Act and Eddie.

Her mother reports that she hass no problems with eating. Within the home setting____will not comply until her mother screams. Her behaviors however, are good for the babysitter. She only acts up when the mother is coming home from work. Mrs. ___reports that ___likes to watch basketbll and that the family does live near a park. ___will not stay in the yard, but will hop the fence and go to that park to watch the boys play basketball. No matter where ___is, she takes off her shoes and socks and does so even for the evaluation. She does enjoy watching sports such as hockey and Football and appears to like contact physical sports. At the present time, Mrs. ___is looking for a different house so that she will not have the difficulties with the park. ___has made several improvement in attending to a task, especially if its something that she enjoys. Aggressive behaviors with others such as kicking, scratching or pulling hair have also shown a decrease. When ____immediate needs or wants are met, she will follow redirection if it is done in a positive manner. There has been a slight decline in her temper tantrum behaviors. At the present time, she will participate in non-preferred activities when a reinforcement is offered. She is more compliant at this point with some reasonable requests. ___does continue to need redirection in the classroom.

DIAGNOSTIC IMPRESSION:

AXIS I - 314.01 - Attention Deficit Hyperactivity Disorder

AXIS II - 318.0 - Moderate mental retardation

AXIS III -Down Syndrome

AXIS IV - Severe

AXIS V - GAF = 40

Page Four
Psychological Evaluation
(Name)

RECOMMENDATONS:

It is therefore deemed clinically necessary, based upon ___above history and diagnosis, that the following recommendations be made for a period of up to 120 days with a clinical review at the end of treatment:

1) ____would benefit from the continued involvement six hours per day, five days per week within the school setting to implement behavioral management program to reduce____ physically aggressive behaviors, her temper tantrums while increasing her attention span and her compliance to reasonable requests.

2) ____would benefit from the involvemtn of a Behavioral Specialist for one hour per week to communicate with ____,her mother, casemanagement and Therapeutic Staff Support person to ensure consistent implementation of the Behavioral Management Program.

Licensed Psychologist

BEHAVIORAL HEALTH REHABILITATION SERVICES

Quarterly Review

Wilkes-Barre, PA 18702

_______continues to receive Behavioral Health Rehabilitation Services, under the auspices of Human Services Consultants during this quarterly review. Initial referral was made by the ______school, Emotional Support Class due to the display of temper tantrum behaviors.

A brief psychological assessment was completed by Dr. ____, licensed psychologist during the referral process. He concluded the following diagnosis: Attention Deficit Hyperactivity Disorder (314.01), Moderate Mental Retardation (318.00), Down's Syndrome. Based on the psychological assessment and based on the needs of ____, a behavioral treatment plan was developed which included a Plan of Care, Service Plan and Behavioral Program. Therapeutic Staff Support met with ___ in her classroom setting. Behavioral Specialist communicated with Therapeutic Staff Support, teacher, parents in order to promote the generalization of behavioral concepts and in order to ensure consistent implementation of the program.

On 2/3/97, ____, licensed psychologist conducted a recertification assessment, and concurred with the previous psychological assessment. The behavioral treatment plan initially in place in the school setting, continues to be utilized.

_____has shown improvement in attending to task (preferred activities). Aggression (hitting, pushing, scratching, kicking, pulling hair) has also been decreased. ____is able to follow redirection when redirection is positive, and when ____immediate wants are met. Temper tantrum behaviors (yelling, pounding, refusing to take direction) has slightly decreased. ___now can participate in activities which are nonpreferred when they are paired with preferred activities, or when reinforcement is offered. _____is also more compliant with reasonable requests. Requests are also paired with redirection, preferred activities, and reinforcement for completion.

_____behavior in the classroom setting continues to show indication for Behavioral Health Rehabilitation Services Rehabilitation Services Therapeutic Staff Support services. The currently existing behavioral program will continue, with Behavioral Specialist requested hours and Therapeutic Staff Support requested hours remaining.

Behavioral Support Project
Sample Case Study

8 year old male

Behavioral Concerns: Physically Aggressive Behaviors
Self-Abusive Behaviors
Noncompliance

BEHAVIORAL HEALTH REHABILITATION SERVICES

Background Summary

(Name)
(Address)

______was referred to Behavioral Health Rehabilitation Services under the auspices of Human Services Consultants by ______School District's Director of Special Education. Referral was made due to the display of hitting, kicking, banging his head against the wall, and noncompliance with teacher's requests. Ongoing communication between _____Area School District, ______, and _____ mother, _____has determined the necessity of behavioral programming in the school setting.

____attends ______School District. Behaviors have been noted by his teachers as disruptive, defiant, and assaultive. _______School District and ______requests behavioral services in the school setting.

Behavioral Specialist

BEHAVIORAL HEALTH REHABILITATION SERVICES

Service Plan

(Name & Address)

I. Presenting Behavioral Concerns:

- Physically Aggressive Behaviors - kicking & hitting.
- Self-Abusive Behavior - banging head against wall.
- Defiance and noncompliance with reasonable requests.

A. Goal

- ____will refrain from the above noted verbally aggressive behaviors.
- ___will refrain from the above mentioned self-abusive behavior.
- ___will be compliant with reasonable requests.

B. Objective

- ____will refrain from the above noted physically aggressive behaviors, and become compliant with reasonable requests; thereby, increasing his appropriate behaviors and enhancing his social and personal pursuits.

C. Activity/Task:

-Behavioral Health Rehabilitation Services will meet with ____ in his ______school.

II. Duration:

-Program will begin 11/96 and will be evaluated for continuation/revision/termination on a quarterly basis in order to meet the current and future needs of _____.

Behavioral Specialist

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Behavioral Health Rehabilitation Services
BEHAVIORAL PROGRAM

Target Behaviors:

1) Physically Aggressive Behaviors - kicking and hitting
2) Self-Abusive Behavior - banging head against the wall
3) Noncompliance with reasonable requests

Program Goals:

1) __________Will display incremental progress towards a goal of 100% of the time over a three month period.
2) __________Will display incremental progress towards a goal of 100% of the time over a three month period.
3) __________will display incremental progress towards a goal of 100% of the time over a three month period.

Behaviors:

- __________will refrain from the display of the above named physically aggressive behaviors and self-abusive behaviors and comply with reasonable requests.

Exchanges:

- Verbal praise and attention

Proactive Strategies:

1) __________will be made aware of all contract terms prior to program implementation.
2) __________will be made aware of sequence of activities throughout TSS involvement.
    a. Any change in the sequence of activities will be explained to __________.
3) Verbal praise and attention will be given to __________ frequently throughout TSS involvement for all appropriate behaviors, as well as for each time activity participation and acceptance to directives is given.
    a. If ________ hesitates to participate in a requested activity with a preferred activity, TSS

should pair the non-preferred activity with a preferred activity; thereby, increasing the probability of participation in the requested task.

4) When TSS observes __________becoming frustrated, he should be offered a preferred activity or a physical activity, in hopes of channeling the excess energy or frustration to a positive outcome.

5) The length of time activity participation is requested will be gradually and systematically increased over time according to _________performance improvement.

6) The terms of this contract may only be modified with the consent of all contracting parties in order to better meet __________ needs.

____________________ Parent ______________________ TSS

_____________Behavioral Specialist__________Psychologist

PSYCHOLOGICAL EVALUATION
(Name)
Birthdate: 05-04-88
November 27, 1996

IDENTIFYING INFORMATION:

______is an eight and one half year old male who was evaluated at the offices of Human Services Consultants. He currently resides in the _____, PA area with his mother and step-father ______. Currently he is in the joint custody of his mother and biological father, ______. However, he spends the majority of his time at the _____household having periodic visits with his father _______.

REASON FOR EVALUATION:

_____is being evaluated to determine the ongoing need for clinical services and, if indicated, the authorization of these services.

RELEVANT INFORMATION:

_____was born approximately 2 months premature with a birth weight of 2 pounds, fifteen and one half ounces. He is observed in ongoing treatment at the Hershey Medical Center until about five years of age although no current medical difficulties presents during the evaluation.

____biological mother and father were separated when he was approximately 11 months of age. It is currently somewhat unclear as to the reason of the separation, but our casework notes seem to indicate that there was some suspicion of abusiveness on the part of _____, the biological father towards his mother. Following this separation, _____ mother, ____, remarried ____. As noted above, ____spends the majority of his time in the ______household which includes his mother, his step-father ____, an 18 year old step-brother, _____. ____indicates that he has a good relationship with his older brother and enjoys a relatively good relationship with his mother. He reports that at times the relationships between he and his step-father are somewhat strained and that there are difficulties in the relationship between the ____ and his father in that there are currently legal proceedings in process regarding custody of____. It is reported that the ____are interested in maintaining full custody of_____, having ____father be allotted only visitation time. Apparently the history related to _____involvement with the _____and his biological father is a significant one.

There are numerous occurrences of____being asked to "lie" about his step-father on the prompting of his biological father. In addition to this, there are some reports of abusiveness inflicted on ____that resulted in Children and Youth involvement with the situation. In addition to the difficulties that _____experiences between his father and mother's families, he presents significant difficulties in the educational setting. He is currently a student in the third grade in the

____Elementary School and, in his words "is not doing so good". He reports that he has been suspended twice and that he has problems related to following rules and aggressive hyperactive kinds of behavior. In addition, he is viewed as being oppositional and defiant and is described as having mood swings. ____tells me that he enjoys school and likes reading. He is concerned that if he gets suspended a third time that "this will be the worst". He tells me that his step-father and mother told him that "they are going to send me to a home - it will be the end of my childhood" regarding his anticipated response to being suspended from school for the third time. His grades apparently are marginal, although he tells me that he has achieved a "B" in mathematics, perhaps on this last test.

____tells me that he has a number of friends, but "they don't call me". when questioned as to the nature and depth of his relationship with others he reports that friends do not become involved with him because "they are too stupid-they think I'm being mean to them". He reports that at times he can become quite angry and "get out of control". _____, as far as I can determine, is currently on no medication. He appears to be in generally good health and seems appropriate in terms of size and weight for his age.

_____tells me he enjoys playing with video games and watching television. He also enjoys playing with board games.

INTERVIEW:

____is an eight and one half year old male who is evaluated at the offices of Human Services Consultants. He is a willing participant in the evaluative process demonstrating no excessive anxiety during this session. I noted no oddities and no unusual mannerisms or behavior during our evaluation.

______spoke in a well modulated tone. His verbalizations were relevant to the topics being discussed and his thinking proceeded in a logical goal-directed fashion. I would say that this verbalizations were within normal limits.

____readily admits to difficulties in controlling aggressive behavior, having problems with mood swings and becoming angry. He is somewhat reluctant to go into any excessive detail regarding his relationship with his biological father and his step-father, preferring to answer in brief responses and move his attention to the activities that he is involved in during the evaluation. He is a young man with a good vocabulary and appears to be a rather bright child. He plays creatively with toys available to him during the evaluation and demonstrates no excessive problems with concentration. He appears a bit hyperactive perhaps an indicator of some degree of anxiety that he felt while being evaluated. He talks about his difficulties with a certain sense of detachment and, although he readily admits to having problems, he has both in the school setting and at home, he does so with little emotional response. He denies any particular difficulties with feeling sad, depressed or anxious. However, one wonders if the irritability and aggressiveness that are well documented in his history are not indicators of depression.

DIAGNOSIS:

Based on the available information, background information and current evaluation, the following diagnosis are suggested:

AXIS I - 311.0 - Depressive Disorder, NOS
Rule out Anxiety Disorder
313.81 - Oppositional Defiance Disorder
Rule out Attention Deficit Hyperactivity Disorder.

AXIS II - No Diagnosis

AXIS III - No Diagnosis

AXIS IV - Problems with primary support group - Moderate to severe.
Problems related to social environment - Moderate to severe.
Educational problems - Moderate to severe.

AXIS V - GAF = 55 - timeframe current

RECOMMENDATIONS:

Based on the available information, mental status and current diagnosis, the following recommendations are viewed as being clinically indicated:

1) A Behavioral Specialist should be involved with ___ to develop a plan that will result in a decrease in aggressive acting out behaviors as well as a reduction in defiant oppositional behaviors.

2) Therapeutic Staff Support should be involved in consistently executing of the behavioral directives.

3) Some attempt to determine the interaction between ____ biological mother and biological father should be undertaken to assist in the determination of appropriate behavioral directives. This "parents" is apparently a long-term difficult situation that may well have resulted in ____presentation of depressive oppositional futures.

Apparently there is significant disagreement between these two factions with ____being the battleground where most disagreements take place.

4) Records and involvement with ____past caregivers including _______ of Children and Youth, ___and ____from Children's Service Center should be undertaken. These records may provide important additional information that can be useful in treatment planning as well as assistance in more specific differential diagnosis. Since ____is involved with legal proceedings regarding custody, some consideration of acting out of control regarding these determinations might be considered. Should symptoms persist, some referral to psychiatric services might be considered to attempt to further outline diagnostic indicators as well as to review treatment considerations and to evaluate the appropriateness of any medications.

, Licensed Psychologist

BEHAVIORAL HEALTH REHABILITATION SERVICES
Plan of Care

(Name)
(Address)
Wilkes-Barre, PA.

______continues to be seen in his _____Area classroom as part of Behavioral Health Rehabilitation Services for children.

Reports from Mrs. _____and Counties Case Management Unit indicated the initial referral was made due to the display of inappropriate behaviors, aggressive behaviors, uncooperative and defiant behaviors that risked his personal safety.

Human Services Consultants Behavioral Health Rehabilitation Services will:

1. Reassess and reevaluate the necessity of behavioral programming in the classroom.
2. Develop the behavioral program, with the assistance of all parties.
3. Implement the behavioral program in order to ensure the needs and the safety of _____are met.
4. Consistently note progress/concerns.
5. Maintain contact with ____, his parents, and all other interested parties in order to communicate progress and/or needs.
6. Attend all IEP meetings as scheduled by the school district.

Behavioral Specialist Consultant (Master's level with 7 years training and experience in behavior modification and crisis intervention will communicate with ____his parents, teachers or Therapeutic Staff Support a minimum of one hour per week in order to ensure the consistent implementation of the behavioral program and to ensure the safety issues are addressed.

Therapeutic Staff Support will meet with ____and his teachers 20 hours per week in order to implement the behavioral program and to ensure the current and future needs of ____are met.

PSYCHOLOGICAL EVALUATION
(NAME)
(ADDRESS)
Birthdate:
February 20, 1997

IDENTIFYING INFORMATION:

______is an eight year old male who is evaluated at the offices of Human Services Consultants. There is no change in his residential situation since his past evaluation dated November 27, 1996. He continues to live with his mother and step-father.

REASON FOR EVALUATION:

_______is being evaluated to determine the ongoing need for clinical services and, if indicated, the reauthorization of these services.

RELEVANT INFORMATION:

The reader is referred to past psychological evaluation dated November 27, 1996 as well as ongoing clinical notes and records from other caregiving agencies for further information regarding ____ developmental history.

As mentioned above, ____continues with his living situation that includes his mother and step-father.

Conversations with clinical staff personnel at Human Services Consultants as well as discussions with _____indicate that there has been a substantial improvement in the behavioral problems that initially brought ___into treatment. It is my understanding that he has achieved, to some degree, in his third grade placement at _____Elementary School and that his defiant oppositional behavior has decreased significantly. He appears to relate well to his clinical staff members from Human Services Consultants and she informs me that this decrease in oppositional defiant type of behavior is present both in the school setting as well as the home setting. Additionally, both she and _____indicate there is a growing awareness as to which behaviors are objectionable and by the use of behavioral planning, there has been a decrease in the objectionable behavior.

As far as I can determine, there continues to be contact with ____biological father. He provides little information regarding this contact and I am not sure about that status of any custody proceedings that may be going on. As mentioned in the earlier psychological evaluation, _____ biological father is clearly an important individual and contact should be initiated and maintained with ____so that we can have his input regarding _____behavior and possibly interventions that would prove most effective.

____tells me that he has developed several friends and seems to be less hesitant to talk about these relationships than was the case during our first evaluation. He continues to appear to be in good health and, as far as I am aware, he is currently on no medications. He continues to tell me that he enjoys playing with video games and watching TV.

_____is somewhat vague in his presentation of his relationship with her mother and step-father as well as his relationship with his biological father. This seems to be an area that he is somewhat reluctant to talk about. Further information gathered through ongoing clinical contact regarding the nature and significance of these relationships appears important.

INTERVIEW:

____is an eight year old male who is evaluated at the offices of Human Services Consultants on an individual basis. He actively engages in the evaluative process. He shows no significant indicators of anxiety during our evaluation. Although initially he had some difficulty in making and maintaining eye contact, he remembers me from our past evaluation and speaks easily with me. He has no difficulty in elaborating on replies when prompted to do so with the exception of the discussions regarding his family.

_____spoke in a soft, well-modulated tone, and amounts of verbalizations was viewed as being within normal limits. There was no blocking or push of speech detected. I was able to easily follow ____train of thought and he spoke in a logical goal-directed fashion.

_____indicates that he feels he is in better control of his aggressive defiant behaviors and talks about having a good relationship with the clinical staff member from Human Services Consultants.

He continues to be somewhat reluctant to talk about his family relationships with any degree of detail and this may well indicate some difficulties in these areas. He is able to focus on whatever is available to him during the evaluation and, to a degree, appears to use this focus as a way to reducing anxiety. _____continues to talk about his difficulties with a sense of detachment and one wonders if there continues to be some depressive features presented by ____.
_____vocabulary is good and he appears to be a rather bright child. He is able to occupy himself with the toys available to him and generally plays in a well behaved manner, although at times his play does become aggressive. He is directed away from this type of behavior with little difficulty by the evaluator.

DIAGNOSIS:

Based on the available information, history, past evaluations and current evaluation, the following diagnosis are suggested.

AXIS I - 311.0 - Depressive Disorder, NOS
313.81 - Oppositional Defiant Disorder

AXIS II - No Diagnosis

AXIS III - No Diagnosis

AXIS IV - Problems with primary support group - Moderate to Severe
Problems related to the social environment - Moderate
Educational problems - Moderate

AXIS V - GAF - 60 - timeframe current

RECOMMENDATIONS:

Based on the available information, past history and mental status, the following recommendations are viewed as being clinically indicated.

1) A Behavioral Specialist should become involved with ____to develop a plan that will result in the decrease in oppositional defiant types of behaviors as well as to maintain the reasonably good level of adjustment that _____has reached in his educational setting. Additionally, some focus should be placed on increasing ____self-esteem as a method of reducing depressive symptoms as well as a vehicle to provide him with self control over defiant oppositional behaviors.

2) Therapeutic Staff Support should be involved to ensure the consistent execution of the behavioral directives. Ongoing contact with ____ mother, step-father and his biological father should be initiated and maintained to assure the consistant execution of behavioral directives as well as to support them in following through with treatment interventions.

3) Increased information regarding relationships that ____ has with his mother, step-father and biological father should be pursued through Therapeutic Staff Support. This information may help in understanding the basis for ____depressive/ anxious types of behaviors as well as his oppositional defiant disorder.

4) Ongoing assessment should also be directed toward either ruling in or ruling out Attention Deficit Hyperactivity Disorder. I am aware of the past evaluation by

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Psychological Evaluation
(Name)

Dr. from with the diagnosis of ADHD. During my two evaluations I did not find the criteria that would allow this diagnosis and, as mentioned earlier, I am not aware of ____being placed on any types of medications. Should ADHD seem a likely diagnosis, some consideration for referral to psychiatric services for medication evaluation may well be indicated. Should past records be missing from ____chart, they should be requested from past caregivers to provide a more complete detailed picture of _______developmental history and past treatment involved.

, Licensed Psychologist

Behavioral Support Project
Sample Case Study

9 year old male

Behavioral Concerns: Physically Aggressive Behaviors
Self-Abusive Behaviors
Noncompliance

Human Services Consultants

265 Wyoming Avenue • Kingston, Pennsylvania 18704-3595 • 717-287-7100 FAX (717)287-8412

Behavioral Health Rehabilitation Services
BACKGROUND SUMMARY

________was referred to Behavioral Health Rehabilitation Services under the auspices of Human Services Consultants by ___________School District's Director of Special Education. Referral was made due to the display of hitting, kicking, banging his head against the wall, and noncompliance with teacher's requests. On-going communication between Area School District, __________and his/her mother, has been determined the necessity of behavioral programming in the school setting.

__________ attends _________ School District, behaviors have been noted by his teachers as disruptive, defiant, and assaultive. School District and __________ requests behavioral services in the school setting.

Behavioral Specialist

BEHAVIORAL HEALTH REHABILITATION SERVICES

Plan of Care

(Address)

_____ was seen in his _____home as part of an initial evaluation for Behavioral Health Rehabilitation Services, under the auspices of Human Services Consultants.

Reports from ____ and _______indicate that ____displays physically aggressive behaviors, self-abusive behaviors, and noncompliant behavior in his school setting. ____school district and ____parents indicate the Behavioral Health Rehabilitation Services would be of benefit to ____.

Human Services Consultants Behavioral Health Rehabilitation Services will:

1. Assess and evaluate the necessity of behavioral programming in the _____classroom.
2. Develop the behavioral program, with the assistance of _____, his parents, teachers, and TSS.
3. Implement the behavioral program in order to ensure the current and future needs of ____are met.

Behavioral Specialist Consultant (Master's level with documented training in the field of behavioral management, and experience in crisis prevention/intervention) will communicate with _____and his parents, his teachers or TSS a maximum of one hour per week (4 units) in order to ensure effective programming, and the generalization of behavioral concepts.

Therapeutic Staff Support (Bachelor's level with documented experience working with children and one year experience in crisis prevention/intervention) will meet with ____in his school up to thirty-five hours per week (60 units), to implement the behavioral program and to ensure the current and future needs are met.

Behavioral Health Rehabilitation Services
Service Plan
(name)
(address)

Presenting behavioral concern:
-physically aggressive behaviors (biting, kicking)
-uncooperative behaviors (refusing to participate in educational activities)
-jeopardizing personal safety (running away)

Goal:
-_____ will decrease physically aggressive behaviors (as noted)
-_____ will increase his participation in educational activities.
-_____ will learn and practice personal safety.

A. Objective:
-_____ will decrease physically aggressive behaviors, increase his communicative behaviors; thereby expressing his wants/needs in a more acceptable fashion.
-_____ will increase his participation in educational activities; thereby enhancing his educational and social development.
-_____ will learn and practice personal safety; thereby enhancing his social activity participation.

B. Activity/Task:
Behavioral Health Rehabilitation Services will visit _____ in the _____school and in his home in order to decrease his physically aggressive behaviors, in order to increase his participation in educational activity, and in order to teach personal safety.

Duration:
Program will begin 8-30-96 and will be evaluated for continuation/revision/termination on a quarterly basis in order to meet the needs of _____.

PSYCHOLOGICAL EVALUATION
(NAME)
(ADDRESS)
Birthdate: July 19, 1987
Chronological Age: 9-6
Grade: Fourth-Learning Support
January 28, 1997

BACKGROUND INFORMATION:

______is a nine year, six month old, white male who is currently involved in Behavioral Health Rehabilitation Services under the auspices of Human Services Consultants due to physically aggressive behaviors such as biting and kicking, uncooperative behaviors in that he refuses to participate in educational activities and also jeopardizing his personal safety by running away from school.

_____is the youngest of five children born to the union of ____(11-12-52) and _____(08-19-51)_____; he does have siblings, ____(07-22-73), _____(02-24-75), ____(03-22-78 and ___(12-04-83). ___is currently involved in a fourth grade Learning Support class placement at the ____School. Approximately two years ago, ____behaviors became out of control and his big thing, when confronted by things he didn't want to do, was to drop on the floor and you couldn't move him. In school he was refusing to do any paperwork. ____was diagnosed with Down Syndrome at birth. However, there were no difficulties with the pregnancy. His mother reports that the labor pains were very erratic and that he was the product of an induced birth. He did weigh seven pounds and one ounce and was nineteen and one half inches long. He did begin walking at eighteen months, talking between nine and twelve months and was toilet trained at four years. Prior to eighteen months of age, ____was involved in the Early Intervention Program through Child Development Counsel. His current MR Caseworker is ____. The mother believes that he was tested at Children's Service Center by Dr. ____. She reports that he was involved with the daycare at the Early Intervention Program in addition to pre-school at the Child Development Counsel and then he started regular school. He did receive speech therapy at Early Intervention and Child Development Counsel Programs.

According to the mother, there were no difficulties in Kindergarten and he did spend three years at the _____School in Wilkes-Barre.

EVALUATION:

____is small for his age, however, his body is in proportion. He is verbal throughout the evaluation. His mother reports that the behavioral problems began approximately two years ago while he was at the _____School and continued this year at the ______Building. At the present time, there has been some improvement in his behaviors in school. However, he continues to have episodes in which, when frustrated, he kicks, throws himself on the floor and refuses to do paperwork. There has been a reduction in the amount of biting and kicking that he does on a daily basis. With the home setting he has been doing much better. His mother reports that he often wants to go outside. However, when he goes out front, he often takes off and they have a difficult time finding him. She reports that last year was real bad and that she had to keep on top of him 24 hours a day.

____does have a great deal of difficulty with his sister ____ and doesn't get along with her at all. He will scream at her and spits in her face. During the past week, his mother reports that he has been doing much better with his paperwork and that he has been getting stars for completed work. During the first couple of weeks, ___would bolt out of his classroom and out of the school. At the present time, this appears to not be a complaint. ____is presently going to school in a station wagon and there are no reported problems. At the end of the school year last year, (the last day of the school year), somebody reportedly kicked or kneed him in the crotch and he had a tough two to three week period after that.

According to his mother, ____does need to learn how to tie his shoes in addition to becoming more self-sufficient. She reports that he does have a tendency to pretend to be lazy in order to get the interaction from the adults in his environment. As previously stated, ____continues to fall to the floor and kick when he does not get his own way.

DIAGNOSTIC IMPRESSIONS:

AXIS I - 313.81 - Oppositional Defiant Disorder

AXIS II - 318.1 - Severe Mental Retardation

AXIS III - Down Syndrome

AXIS IV - Unspecified

AXIS V - GAF = 45

RECOMMENDATIONS:

It is therefore deemed clinically necessary, based upon ____above history and diagnosis that the following recommendations be made for a period of up to 120 days with a clinical review at the end of treatment:

1) ____would benefit from the continued involvement of a Therapeutic Staff Support person for up to 20 hours per week to implement the Behavior Management Program, to reduce his physically aggressive behaviors, to facilitate his cooperation

in educational activities and also to foster continued restraint in the runaway behaviors.

2) The involvement of a Behavior Specialist for up to one hour per week will continue to communicate with ___, his parents, teacher and Therapeutic Staff Support to ensure that consistent implementation of the Behavioral Management Program is realized.

, Licensed Psychologist

Human Services Consultants

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BEHAVIORAL HEALTH REHABILITATION SERVICES

BEHAVIORAL PROGRAM

Wilkes-Barre, PA.

Target Behaviors:

1. Physically Aggressive Behaviors (biting, kicking).
2. Uncooperative Behaviors (refusing to participate in educational activities).
3. Jeopardizing personal safety (running away).

Program Goals:

1. ________ will refrain from the above named physically aggressive behaviors.
2. ________ will increase his activity participation.
3. ________ will learn and practice personal safety.

Proactive Strategies/Positive Approaches:

The following proactive strategies will be addressed and implemented throughout the course of the day:

1. ________will be made aware of all events of the day, particularly during his school hours. Keeping ________ informed of the sequence of events while at school will remind him of the expectations and rules of his classroom.
2. If there is a change in schedule, ________ will be informed of the change and an explanation of the change in schedule will be offered. This is done to give ______ the time he may need to adjust to the change in routine.
3. As ______ participates in a preferred activity, TSS/teachers/parents should explain to ______ environmental dangers, both inside the home and the school, and in his surroundings. This is done to emphasize personal safety, not to emphasize __________personal environmental fears.
4. If ________ is to participate in a nonpreferred activity and he displays resistance, the nonpreferred activity should be paired with a strong preferred activity, to be enjoyed upon completion of the required task.
5. If _______ begins to initiate physically aggressive behaviors, he is to be redirected to a positive activity or a positive area in his surroundings. TSS/teachers/parents should, in a calm voice, ask to relate why the behavior occurred and offer him alternative choices for behavior.

Contract Terms:

1. ________ will be made aware of all contract terms prior to program implementation.
2. ________will be monitored according to specific intervals determined by baseline activity.

  A. Token reinforcement (stickers, sticker card), according to specific intervals, will be given for absence of discrete expected behaviors (physically aggressive behaviors, as noted above).
  B. Length of intervals will be gradually and systematically increased over time according to performance improvement.

3. The terms of this contract may only be modified with the consent of all contracting parties.
4. This behavioral program will be consistently reviewed for continuation/ revision or termination.
5. Signatures:

Goal Sheets:

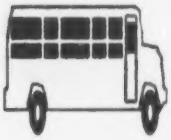
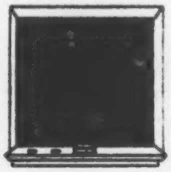
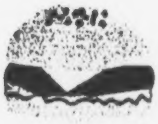
Goal sheets were developed by the Bloomsburg University Interns and used as a visual representation of a child's progress in attaining selected goals.

My Behavior Chart
Robert Croop

This sticker chart is very similar to the one that my TSS used with her student. It is designed so that at the end of the day, you can discuss the student's behavior in several different areas. This chart contains playtime, morning bus ride, cleanup time, lesson time, and lunch. If the student behaved during these time periods, then a sticker will be placed in the appropriate box. If the student misbehaved during one of these time slots, then no sticker is given. At the end of the week you count up the stickers and see if there are enough to earn a prize. The number needed can vary.

by Robert Croop

My Behavior Chart

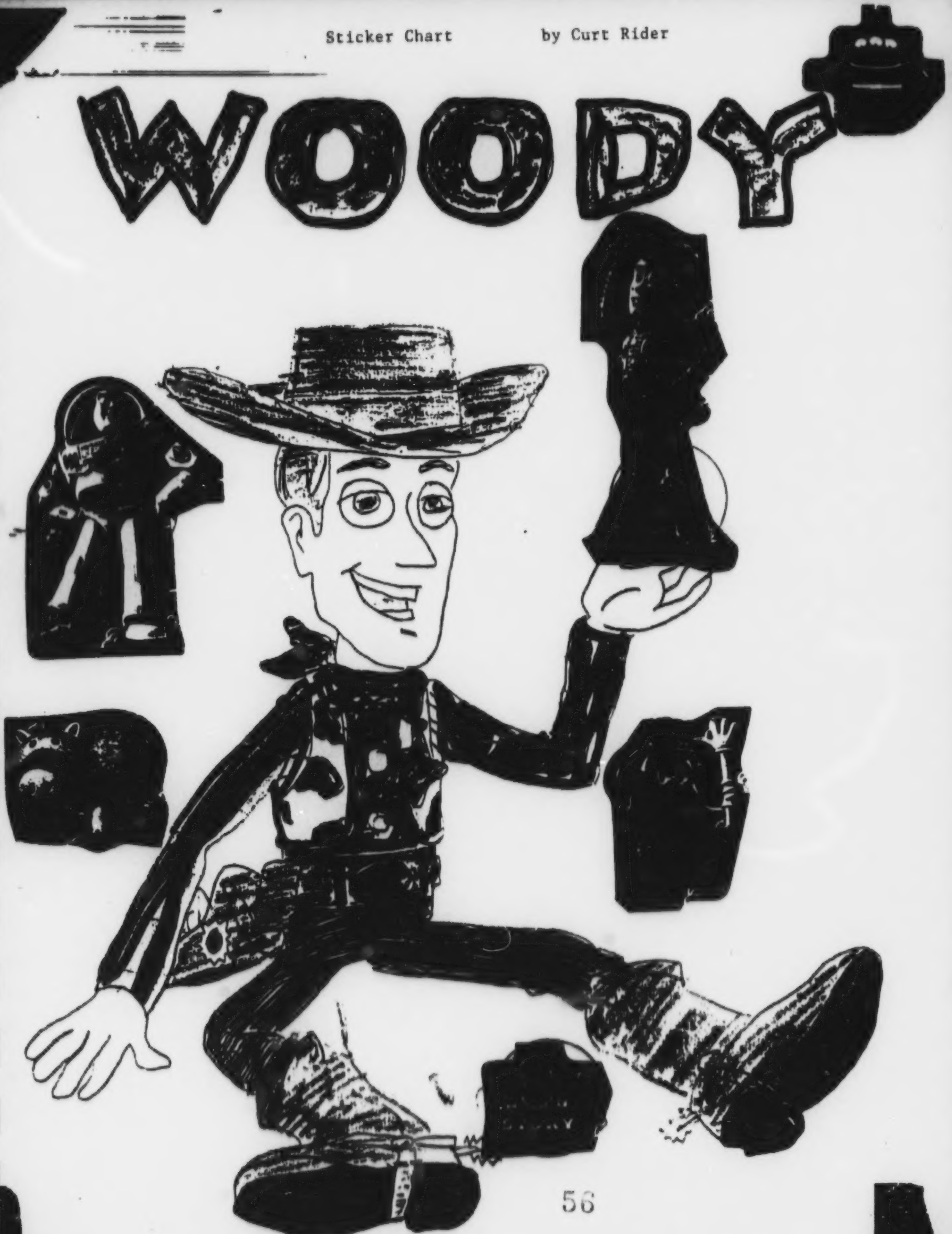
	Monday	Tuesday	Wednesday	Thursday	Friday
					
					
					

STICKER CHART

Curt Rider

On the following page is an example of a sticker chart that I used with a student in an attempt to eliminate constant pushing of others during recess and gym. Since sticker charts don't usually work with this child, the TSS and I tried to make it more appealing by selecting the character "Woody" from Toy Story which the child really liked. The sticker chart worked at first, but then the child lost interest. Though my sticker chart failed, I like the idea of using sticker charts because it visually shows progress made in accomplishing goals.

Sticker Chart by Curt Rider



BEST COPY AVAILABLE

Criteria for Sticker Chart:

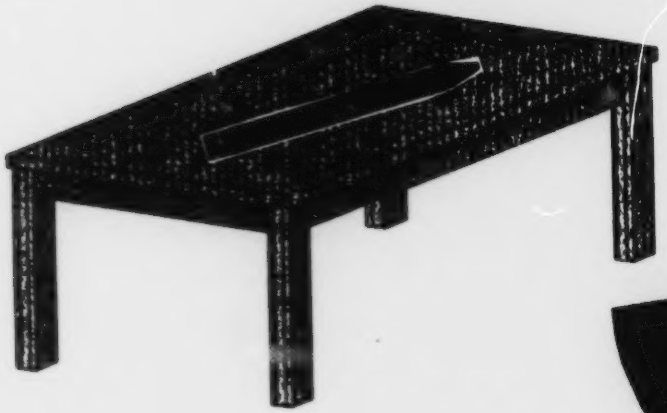
One crayon will be moved on a daily basis until all eight crayons are in the box. If the student is given less than three warnings and does not have to be removed from his desk or the lesson area (i.e., story corner) during the two-hour session, the crayon will be moved to the table. If the student accumulates no more than one time-out during the two hours, the crayon will be put in the box.

Nevertheless, if three warnings are given or it is necessary for the student to be removed from his desk or the lesson area, the crayon will not move be moved to the table. If, however, a time-out is not given, the crayon will move to the table and the process will continue the next day with the same crayon until it is placed in the box. If warnings, removal, and time-outs are given during the allotted time, the crayon will not move from its original position. The crayon will never be moved back to its previous position because the position was earned.

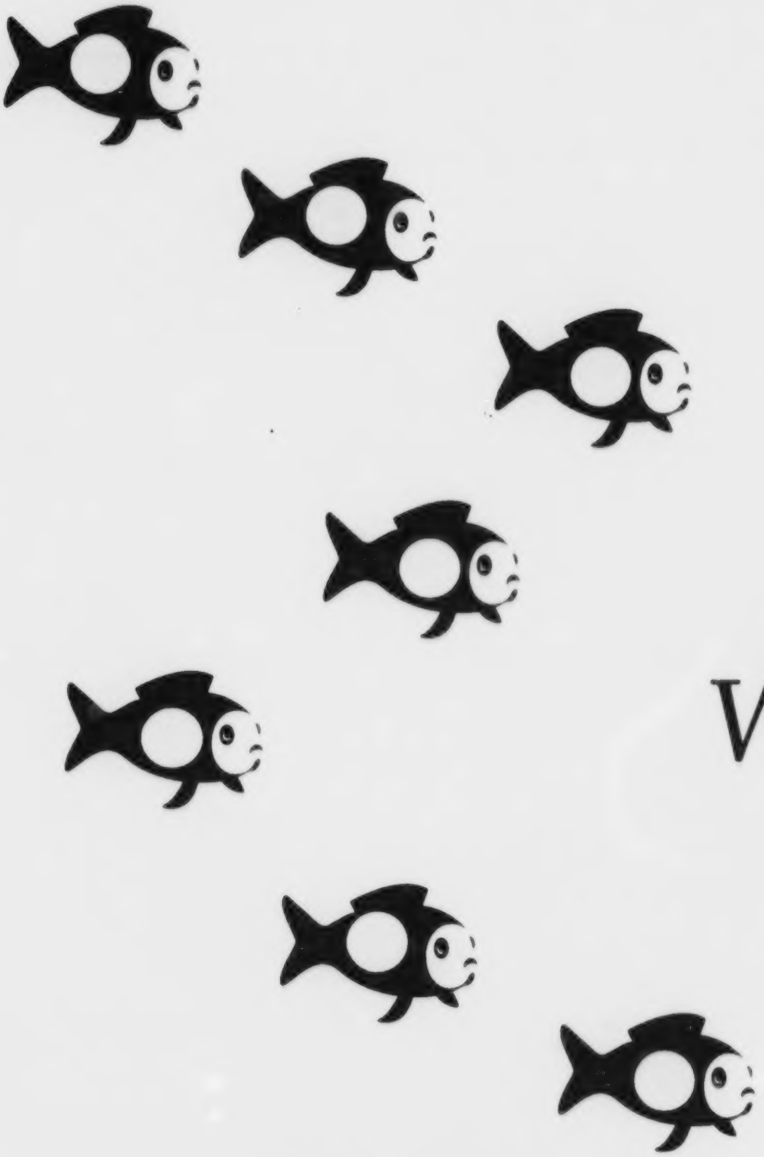
When all eight crayons are in the crayon box, the student will be given the reward: a 64-count crayon box.

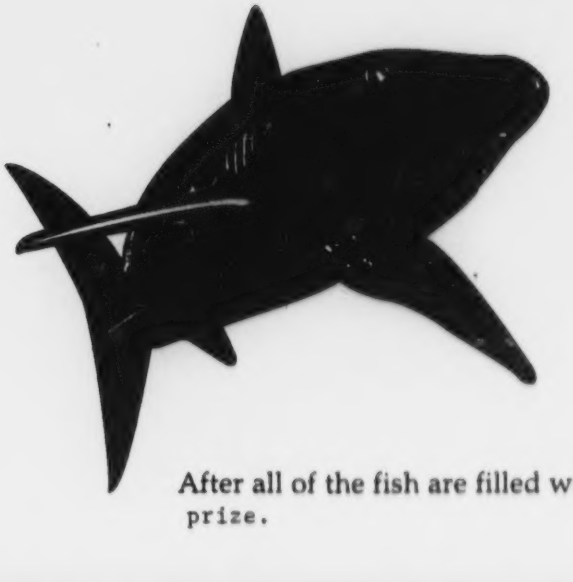
by Sariann Knerr

Put the Crayons in the Box



Gobble Your Way To Success





After all of the fish are filled with stickers, you have succeeded and will get a prize.

J. Rebecca Howell

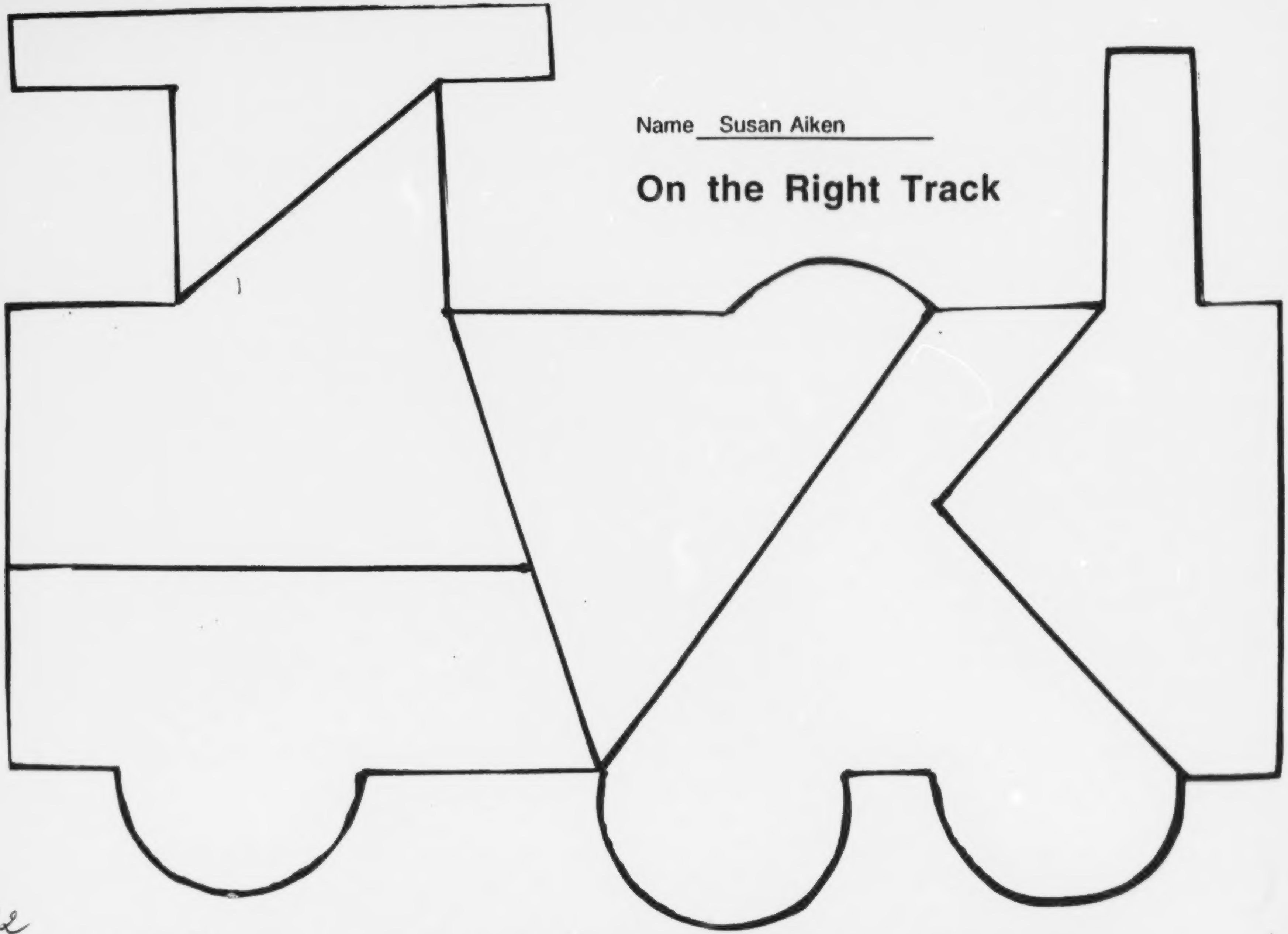
Swing Your Way to Success

Fill in all of the circles with stickers by displaying good behavior and get a super surprise

Kristin McElroy

Name Susan Aiken

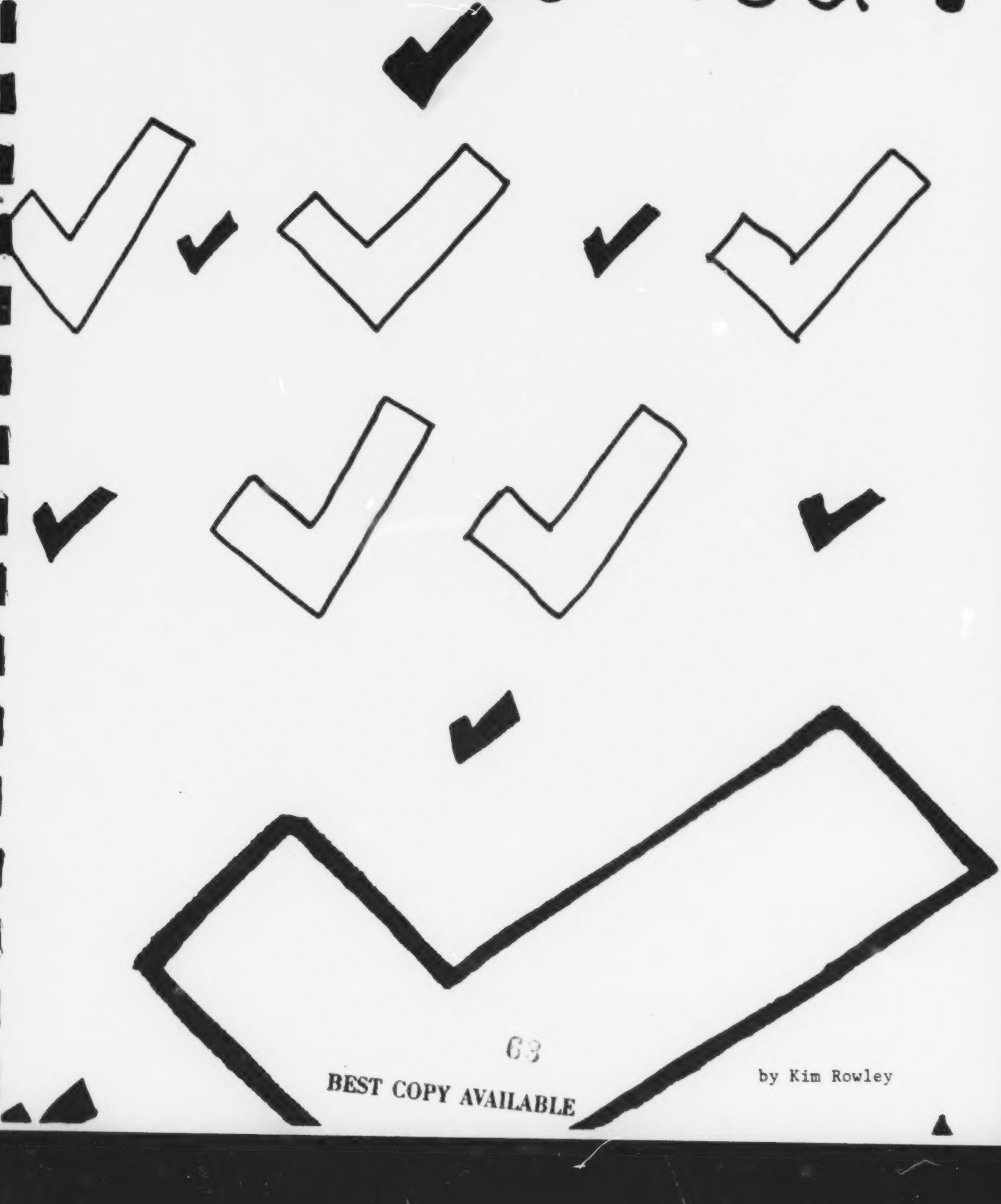
On the Right Track



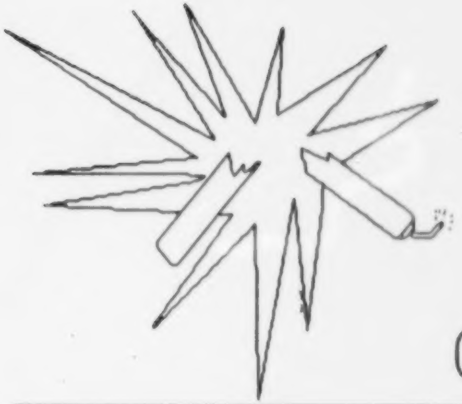
Cut puzzle pieces apart and glue each piece onto a sheet of construction paper as goal is achieved.

Each student will color in a checkmark when s/he does a good deed. Once all the checkmarks are colored including the big red Checkmark, the student gets a reward

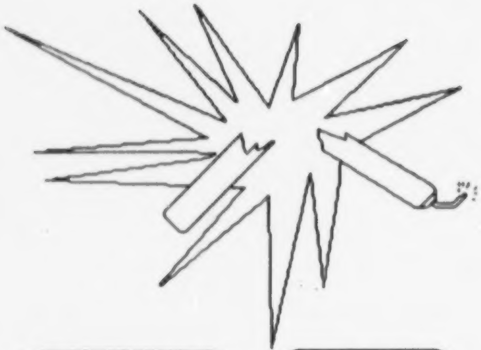
CHECK ME OUT!



by Kim Rowley



JENNIFER



Week: ______________

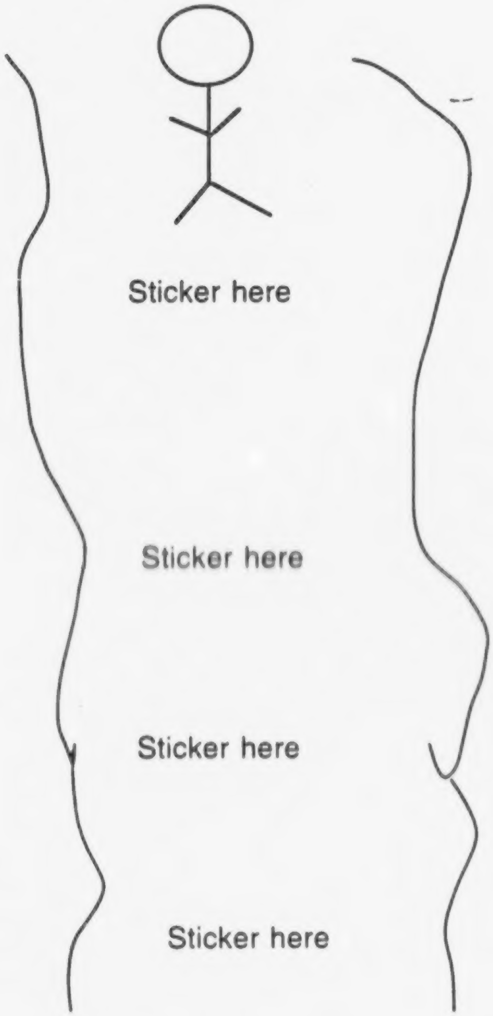
	Monday	Tuesday	Wednesday	Thursday	Friday
I talked politely to my friends and teachers today.					
I kept my hands to myself today.					
I kept proper distance when talking to others today.					
I followed all of the classroom rules today.					
I had a behaved appropriately in lunch today!					

By: Patricia Lutz

by Rochelle Loy

SKIP TO YOUR GOAL

1. I listened to the teacher today.
2. I stayed seated during class time.
3. I did not talk back to the teacher.
4. I raised my hand before I spoke to the teacher.
5. I did not refuse to to do work.



I knew you could do it!!!

by Cathy Angradi

REACH FOR THE STARS

ELLEN

by Kerry Hayes

Steps to

I will keep my hands and feet to myself.

2) I will stay in Circle.

3) I will share in free play.

Success!!!

V. Review of Related Literature:

POSITIVE AND NEGATIVE REINFORCEMENTS

Marcus, B.A., & Vollmer, T.R. (1995). Effects of Differential Negative Reinforcement on Disruption and Compliance. Journal of Applied Behavioral Analysis, 28, 229-230.

Disruption and noncompliance during instructional activity are among the most challenging behaviors displayed by children with developmental disabilities. Treatment of disruptive noncompliance has included antecedent manipulations, differential reinforcement, escape extinction, and functional communication training. Each of these interventions typically increase appropriate behavior (compliance or communication) concurrent with decreases in aberrant behavior.

Dilnavaz, K.B., Burns, W.J., & Montgomery, D.D. (1996). Computer-Assisted Cognitive Training for ADHD. Behavior Modification, 20(1), 85-90.

Several different intervention procedures such as self-instructional training, cognitive modeling, self-monitoring, self-reinforcement and cognitive and interpersonal problem solving have been developed to treat attention deficit disorder in children. Studies using these methods have found moderate and short-term improvement in cognitive or behavioral functioning. However, development of personal computers has increased the scope of cognitive rehabilitation and training.

DOWN'S SYNDROME

Berkell, D.E., Mallgeri, S.E., & Streit, M.K. (1996). Auditory integration training for individuals with autism. Education and Training in Mental Retardation and Development Disabilities, 31(1), 66-70.

Earplugs or industrial protective ear covers have been helpful in some cases; however, many individuals with autism refuse to wear these devices, and muffling sounds diminishes the ability to hear speech and other environmental auditory stimuli.

Diller, L.H., Tanner, J.L., & Weil, J. (1996) Etiology of Attention Deficit Hyperactivity Disorder: Nature or nurture? American Journal of Psychiatry, 153(3), 451-452.

The failure to consider potential environmental factors adds to the tendency to treat Attention Deficit Hyperactivity Disorder as an exclusively neurological disorder that is to be solely treated through medication.

Farlow, L. (1996, February). A quartet of success stories: How to make inclusion work. Educational Leadership, 53(5), 51-55.

Jobe, D., Rust, J.O., & Brissie, J. (1995). Teacher attitudes toward inclusion of students with disabilities into regular classrooms.
Education, 117(1), 148-152.

Inclusion differs from mainstreaming in that in the inclusive program the children with disabilities are the shared responsibility of the classroom teacher and other support professionals.

Melnick, S.M., Barkley, S.P. (1996). What they want and what they get: The social goals of boys with Attention Deficit Hyperactivity Disorder and comparison boys.
Journal of Abnormal Child Psychology, 24(2), 169-185.

The association between children's social goals and their overall peer acceptance was also measured. In their self-reports, ADHD - high aggressive boys prioritized trouble seeking and fun at the expense of rules to a greater extent, than did both ADHD - low aggressive and comparison boys. Observers judged ADHD - highly aggressive boys to seek attention more strongly and seek fairness less strongly than the other two groups.

DOWN'S SYNDROME (continued)

Pires da Cunha, R., & Belmiro de Castro Moreira, B. (1996, August). Ocular findings in Down's Syndrome. American Journal of Ophthalmology, 122, 236-244.

We also found that astigmatism, iris anomalies, and strabismus were more common in children age five years and older compared with the group of children younger than five years. Hyperopia was more prevalent in children 12 years of age and older compared with younger children. Children with congenital cardiopathy and Down's Syndrome had proportionally more myopia or myopic astigmatism than did the children without these cardiac malfunctions.

Schlein, S.J., Mustonen, T., & Rynders, J.E. (1995). Participation of children with autism and non-disabled peers in a cooperatively structured community art program. Journal of Autism and Developmental Disorders, 225(4), 397-412.

One frequently used strategy is the "Special Friends" program, which encourages the development of dyadic relationships between students with severe disabilities and nondisabled peers through participation in weekly information sessions for non-disabled Special Friends, and participation of students with and without disabilities in everyday leisure activities that stress socialization.

AUTISM:

Anusavice, S. (1995, August). Ensuring success for students with ADD. Learning, 24(1), 58.

Teach and model organizational skills. Because a child with ADD may have trouble reading body language and extracting main ideas from a presentation, explain the meaning of specific verbal and nonverbal cues and establish a method for note-taking.

Armstrong, T. (1996, February). A holistic approach to Attention Deficit Disorder. Educational Leadership, 53(5), 34-36.

Internal empowerment, rather than external control is often the best way to help kids diagnosed as having ADHD.

August, G.M. (1996). Prevalence of ADHD and comorbid disorders among elementary school children screened for disruptive behavior. Journal of Abnormal Child Psychology, 24, 571-596.

Using both prospective and retrospective longitudinal designs, these early studies reported that over 50% of children diagnosed with hyperactivity or ADHD were at risk for CD and drug abuse as adolescents or adults.

Baren, M. (1995, December). What ADD is - and isn't. Patient Care, 29(20), 56-70.

DSM - IV offers some protection against over diagnosis of ADHD by excluding children whose problems began after age 7, those who have trouble at home but not in school (or vice versa), and those whose behavior can be traced to psychosis; mood, anxiety, or personality disorder; or learning or language disabilities.

Chrisholm, P. (1996, March). The ADD dilemma: Is Ritalin the best way to treat attention deficit disorder? Maclean's, 109(11), 42-45.

Rickhi's method uses lights and sounds to stimulate the chemical pathway that ADD children lack.

Cramond, B. (1994). Attention Deficit Hyperactivity Disorder and Creativity - What is the connection? Journal of Creative Behavior, 28(3), 193-206.

Because there appears to be considerable concordance in the identifying characteristics, and because both creativity and ADHD are often determined with behavioral checklist, there is a possibility that exhibition of the same behaviors could result in two very different diagnoses

ATTENTION DEFICIT HYPERACTIVITY DISORDER

AUTISM (continued):

Dolby, V. (1997, February). There are a variety of time-tested treatments for childhood ADD. Better Nutrition, 59(2), 48.

While conventional treatments may be of some help, breakthrough research suggests that ADD may be linked to nutrition.

Kirby, E.A., & Kirby, S.H. (1994). Classroom Discipline with Attention Deficit Hyperactivity Disorder. Contemporary Education, 65(3), 142-144.

ADHD children are often discipline problems; however, unlike the conduct disorder child, their disruptive behavior is usually not willful or intentional.

Leutwyler, K. (1996, August). Paying attention. Science American. 12 - 14.

By some estimates, 5 to 6 percent of all school-age boys in the U.S. take Ritalin for this condition.

McFarland, D.L. (1995, Summer). Educating Attention Deficit Hyperactivity Disorder Children. Education, 115, 597-603.

Attention Deficit Hyperactivity Disorder may affect 3 to 10 percent of school age children.

Taylor, J., O'Reilly, M., & Lancioni, G. (1996). An evaluation of an ongoing consultation model to train teachers to treat challenging behavior. International Journal of Disability, Development and Education, 43(3), 203-218.

General education teachers who work in inclusive settings need to demonstrate beliefs and skills that will allow them to address the diverse needs of their students with learning disabilities.

Thompson, A. (1996, February). Attention Deficit Hyperactivity Disorder; A parent's perspective. Phi Delta Kappan, 77, 433-436.

It is important for parents of a child with ADHD to receive supportive instruction in behavior management techniques that are designed to enhance the child's attention to household tasks and rules.

ATTENTION DEFICIT HYPERACTIVITY DISORDER

AUTISM (continued):

Travis, J. (1995, November 25). Imaging hyperactive brains. Science New, 148, 360.

> ...there is normally an asymmetry in volume between the left and right hemispheres of the brain, with the right side of each region being larger. But in ADHD boys, that asymmetry is absent.

Valz, R.E., Weinberg, L.S. (1995, January). Overreacting to Attention Deficit Disorder. USA Today, 123(2596), 84-86.

> Prescription for cerebral stimulants such as Ritalin, were -- and still are -- written too often as a convenient solution for parents and teachers.

Weaver, C. (1994, May/June). Reaching kids with Attention Deficit Disorders: Why whole language helps. Instructor, 103(9), 39-43.

> Move towards a project based classroom. Discover your students' interests and organize units of study around them. Give kids many different methods for showing what they know --oral presentations, art projects, creative drama, and so forth.

VII. Bloomsburg University Interns' Self Reflections:

"What I learned":

I learned not to schedule too many tests in one day for any student. One particular student was non-compliant because he didn't want to be tested anymore.

I learned to be firm and consistent with each child. The head teacher was very firm and consistent in her manner.

I learned that children will procrastinate and do anything to get out of doing their schoolwork. There are many ways to distract the teacher and some may be more obvious than other ways. I have to be on the lookout for all these types of behaviors.

I learned that I need to be more firm with a student when he compliments me. I know now that he is trying to distract me from my school work and is not really complimenting me.

I learned to be conscientious. A teacher has to have her eyes wandering in every corner of the room.

I learned a behavior method from my TSS today. He told me not to put the child in time out. He also told me to forget what the child has done after the incident has occurred.

I learned ways to foster social competence in a child. I was modeling positive reinforcement for all children. One child heard me say how nice it was that the other one drew a picture for his peer and he drew a picture for the child in return.

I learned to model appropriate behavior during play time so children can see how to share and not to push other kids around.

I learned that a teacher can often help a student perform better academically and behaviorally if she provides one-on-one time working with the student. I observed an occasion where the student was not responding to whole group instruction, because she did not understand the lesson. As a result, the student acted out in order to get attention. When the teacher came to her side and provided one-on-one instruction, she understood the activity and exhibited appropriate behaviors.

I learned that often times a student's misbehavior is driven by underlying factors, such as a family situation or a medical condition. Therefore, a child who is misbehaving may not be acting inappropriate for the sole purpose of being "bad."

I learned that the lack of social skills can often lead to misbehavior. One particular student had poor table manners. Other students teased her at the lunch table because of her poor manners. This lead her to misbehave during lunch and lose lunch privileges. Working on table manners seem to solve this problem.

I learned that modeling is an excellent approach to teach appropriate behaviors. Not only does the child directly observe the appropriate behaviors, but she will also learn these appropriate behaviors in a manner that is fun. I observed a TSS model appropriate table manners to a student. The results of the modeling were excellent.

I learned that often times it is appropriate to provide a "cool off" area where the child is allowed to collect herself before reentering the learning atmosphere. This "cool off" time enables the child to regain control of her emotions.

I learned that time-out, when used properly, is an effective method to modify behavior.

I learned that is often necessary to motivate children to behave appropriately with peers. The student I was working with earned a sticker each day when he talked nicely to two or more of his peers. This was an effective way to inspire interaction with other students.

I learned that it is imperative to reinforce appropriate behaviors. Each day when the TSS left her student she asked him: "What good behaviors are you going to do this afternoon while I am gone?" The student responded with the good behaviors he knew were appropriate and thereby reinforced them for himself.

I learned that it is crucial to hold students responsible for their actions, either appropriate or inappropriate. If you ignore a situation or if you are not firm in delegating the consequences of an inappropriate behavior, the student may or may not realize that his behaviors are inappropriate, and will continue them.

I learned that one way to aid in the academic performance of a child with ADHD is to sit by his desk and keep him focused on the task. If he strays from the task you must redirect and help him focus. The desk should also be completely clear, excluding the materials necessary for the lesson, so no unnecessary distractions are present.

I learned that when a child resists your redirection, it is imperative to be firm. It is often useful to talk and thereby reason with the child. If the child gives no logical excuse for why she is resisting, then often she will see that it is only logical for her to follow the instruction and avoid punishment. If she gives a viable excuse for why she is resisting redirection, you will gain insight on why she misbehaves.

I learned that often times a student will resist redirection in a physical manner. If you want to be effective in this situation, you can not let the child know that you are threatened by her advances, even if your are.

I learned that in order to gain support from a parent/guardian one must communicate with them. One way to communicate with parents is through a daily journal that the student must take home and have her parent/guardian sign. In this way, the TSS can describe the student's behavior throughout the day to the parent/guardian and the parent/guardian has the opportunity to respond or ask any questions to the TSS via writing in the journal. Other effective ways of communicating with parents/guardians that I observed are through telephone calls and home visits.

I learned that if you want to gain support from the parents/guardians, you can not go to the parent/guardian with the attitude that they are doing a bad job and that you are there to "fix" their child's behavior. Mutual respect must be present if you want a program to succeed.

I learned that if you do not have parental/guardian support, any behavior program that you develop will not succeed. The child spends a majority of her time with parent(s)/guardian(s) and if they are not willing to reinforce appropriate behaviors that the TSS is emphasizing, then the appropriate behaviors are going to have to be relearned each time the student works with the TSS, hence retarding the progress of the student.

I learned that it is unethical, as well as inappropriate, for a TSS or others working with the student to discuss behaviors or the history of the child to a colleague. Neither is it appropriate to gossip about situations that have occurred throughout the day.

I learned that a student receiving therapeutic staff support services needs to be reassessed to determine if the designed program is effective. The student that I was working with got reassessed after approximately five months of therapeutic staff support services. The reassessment included interviews with the TSS, parent, and child. The psychologist determined that the student was improving and her hours for TSS services were reduced.

I learned that the TSS and other persons working with a behavior problem child must review their own techniques to determine if they are successfully helping the student achieve the desired behavior. The TSS often reviewed the goal charts that she constructed for her students. Occasionally she modified the charts if the student "out grew" it or if it was not helping the student achieve the desired behaviors.

I learned that a student must assess her own behavior. The TSS asked the student to describe her good behaviors as well as her bad behaviors for the day. In this way, the student was assessing her own behaviors.

I learned that a good strategy to assess the effectiveness of an intervention program, is a goal sheet. The desired goals of the program are presented to the child in a chart format and the child is motivated, through stickers or small toys. to perform accordingly to reach the goals.

I learned that to ensure program effectiveness, TSS's and others working with the student must remain knowledgeable on various new ways to help students achieve their various goals. This can be done through research or by attending seminars.

I learned that a program can only be effective if the parents, teachers, school administrators and TSS all communicate. The TSS I worked with maintained an excellent rapport with the parents, teachers, school officials and peers of the students with whom she worked. Only when communication is open, will all parties involved be working together toward a common goal - helping the child.

I learned that by consulting with supervisors as well as colleagues one can gain a better understanding, a different perspective, or advice from others who are trained or being trained in handling children with behavior problems. Often by meeting and discussing my intern experience with colleagues, I learned new methods that were useful when working with my student. I also gained a perspective on new situations that I was not working in such as a head start situation as well as a situation with an adolescent.

I learned through my research that often times a student with ADHD behaves inappropriately not because he wants to, but because he has no choice. Often times a child with ADHD feels controlled by their condition. I also learned various techniques on how to modify ADHD behaviors as well as how to deal with them, such as through peer tutoring.

I learned that in order to keep abreast of current trends in behavior modification it is imperative that you research and search different resources.

I learned that some students have difficulty distinguishing between right and wrong She did not comprehend why it was wrong to undress in the classroom.

I learned that in order to make a child responsible for their own actions, you must be firm in providing consequences for their misbehavior

I learned that while a child is throwing a tantrum, it is best to walk away from the child and let them work it out. If you approach the child, you are just giving them the attention they want and the behavior will worsen.

I learned that even a small reward, such as a pencil, has a great effect on children. One girl seemed genuinely pleased with herself for completing the sticker chart and ecstatic over her reward.

I learned that children need attention. A TSS gave attetion to a young girl by just conversing with her. It was obvious that this child valued this individualized attention from her TSS.

I learned that sometimes the best thing that you can do for a child when he is upset is just to let him alone for a couple of minutes and approach him later. He is more calm and able to discuss his behavior and alternatives to his misbehavior.

I learned when a child is engaged in an activity she enjoys, it is best not to correct her for mild misbehavior because that can be discouraging for her.

I learned that children become attached to people easily (especially adults they work with daily). Even though the TSS served as a strict disciplinarian, the student respected her greatly.

I learned how to effectively thwart student aggression. A particular little girl was immediately placed in timeout because of her aggressive behavior. After she calmed down, we discussed her inappropriate behavior and alternative behaviors.

I learned that in order for a child to succeed in school, his self-esteem has to be high. By making a young boy feel important, the TSS raised his self-esteem and self-confidence.

I learned that one must be firm. A student repeatedly said he did not care when I threatened to take his recess pass away. Although, when I acted on my threat, he was not pleased with the consequences. He was testing me, and he learned that I am not going to give in.

I learned that the best way to achieve certain behaviors is by "doing what I do." Modeling is an enjoyable technique that produces positive results.

I learned that when a child attempts physical actions, one must not show fear and be firm with punishment.

I learned that there are certain instances when you have to remove the student from the present environment to "regroup" himself.

I learned that in order to refocus a student, and to show him that his behavior is inappropriate, a technique such as timeout can be effective.

I learned that taking certain privileges away, such a recess, and having the student earn it back, can be an effective tool in making the student comply.

I learned that you must expect the unexpected, and be sure to pay close attention and try not to be distracted by anything else.

I learned not to make a mountain out of a mole hill. In one case, a student was interested in a certain magazine that another student had. The student kept grabbing it away from the other student. The TSS redirected the student and gave her a different magazine with the same content.

When faced with the problem of a student pushing another student, I learned that instead of repeatedly telling the student to stop, it is best to curb the behavior from the onset.

During a reading lesson, a student refused to sit in the reading circle. I learned to set an example and be a model. I myself went over and sat down in the circle. The student followed my actions and came over and sat down.

I learned that getting down face to face with a student is more effective than standing up and looking down.

I learned that it can be effective to have students work for rewards. The student wanted a particular object, but the TSS would not give it to her unless the student finished her work. When she completed her work, the object was received.

I learned it is important to let the student know that there is a difference between what is appropriate at home and what is appropriate for school.

I learned that just by sitting with a child, can have a tremendous effect on him.

I learned that redirection works.

It is important to have good communication between teachers and therapists. It makes it easier for everyone and makes a pleasing environment to work in.

I learned again, that rewards work. Also, it is a lot harder to give out positives than negatives. What I mean is it is easy to pick out the faults rather than the positives, but positives are more effective.

I learned that sometimes, students need physical contact, whether it be a hug, a pat on the back, or a handshake. Also, that the therapist or intern must make "that bond" between student and teacher. You can make a difference.

I learned that their are restraining techniques that can be applied, such as sitting behind a student, or putting your feet behind the chair, or just sitting with the student and keeping the student involved by singing along, or following along with a lesson. Also hand signals can be helpful.

I learned that it's important to watch the student at all times.

I learned that when the student acts disruptive in class, the best resolution is to take him out of the room so he doesn't further disrupt the class. Once out of the room, it's necessary to keep him focused on his class work because he's easily distracted and looks for ways to get out of doing his work.

I learned that "bad" is not a good word to use with a student.

I learned that sometimes in order to get the student's attention, I must use a firm, confident voice so they know I'm not playing games and that I mean business.

I learned that I had given a student too many warnings. The TSS said that three should be the limit before sending him back to his seat. If he continues his behavior, then he needs to be taken out for a timeout. I realize that the student was aware of the change-of-command and that he was testing me to see how far he could go before I said something.

I learned that it is extremely important to provide as much verbal praise as possible when the student is cooperating and being attentive.

I learned it is best to stay on top of the student and be stern with warnings. Students also need consistency. There are students who have many people in and out of their lives on a daily basis. Changing TSS's, even for one day, can disrupt the behavior modification plan that is in place. The student starts regressing and reverting to his old behavior

I learned that sometimes you just have to stop being so stern and stop demanding and let the student do his work. After all, they are children and they should enjoy learning, not consider it a chore.

I learned that it is necessary to stop a student from disrupting the class. However, I do not feel that restraining the student is appropriate. One student became very aggressive and angry and struggled to get free. I know I'd feel the same way. She was so upset, that she almost hit the teacher when she came over to talk to her.

I learned that you just have to get in there and do it. I was apprehensive at first because I've never been around children who are mentally challenged. I wasn't sure how to relate to them. I discovered, however, that they are basically like non-handicapped kids; they want to have fun, need reassurance, and are eager to learn. Plus, I enjoyed myself, too.

I learned that it takes very little to make children happy. A teacher planned an Easter egg hunt for the class, in which she placed colorful plastic eggs out in the open for the children to find. When they opened them later in the classroom, they just couldn't believe that candy treats were inside. Everyone kept showing me their collection. The kindergarten teacher in this class really goes out of the way to give these children a positive experience. The joy on their faces must be an excellent reward.

I learned that sometimes, no matter how hard you push the student or how patient you try to be, the student may not cooperate. While in timeout, the kindergarten teacher was holding a student's hands so she wouldn't bite her fingers. She became very angry and frustrated. The teacher explained that she must do her seat work. Unfortunately, she was so upset that she wasn't even listening. I think that it's just best to let the student alone at this point because it comes down to who is stronger--the student or the teacher. Anger flares and the situation isn't resolved.

I learned through one child's occupational therapist that children with special needs sometimes have problems with their vestibular system. Placing them on a swing helps to calm them down and get them to focus. Next, she worked on hand-eye coordination with a child using a foam baseball bat and a balloon. After this, she worked on forming the letters A and B with wooden sticks and attempted to get the student to write the letter A. The wooden sticks were doable but the student had a hard time forming the letter A with a marker. Since she had been cooperative throughout the session, the occupational therapist rewarded the student by allowing her to play with bubbles.

I learned that the purpose behind playing with the bubbles was to help the student strengthen the muscles in her mouth. This helps with forming vocabulary words and pronouncing them. The occupational therapist told me that some people don't believe that it helps with speech but she thinks that it has definite benefits. By blowing the bubbles, a student gets practice forcing her breath out and hopefully, will recall this exercise when she is told to speak. Another plus is that the student has fun with the bubbles while doing work.

I learned how thrilling it can be to hear a child say your name after believing that he/she probably doesn't know it. When the student spoke my name, I was just filled with happiness and joy. To me, this means that I must be getting through and touching their life. The child knows who I am and sees me as part of their world. Even though others may not understand what I felt, it made a world of difference to me.

I learned hugging a student may get teachers in trouble. However, I didn't think twice about picking up one student and hugging her. Most of the students in this living skills class seek affection throughout the day. I believe the student was reaching out to me for some affection and that she also forgot my name and this was her way of asking for it and making a connection. Picking her up and hugging her just seemed natural. I do realize that it is important to make sure that other adults are around so that they can be witnesses in case of problems.

I learned that sometimes, no matter how much coaxing or pleading or demanding, a student will refuse to do their work. Because of one student's refusal, I tried something different--showing her what to do instead of telling her. When she saw that I was coloring, she decided to give it a try. It made me feel good because I didn't have to argue with her to get it done. I just spoke to her as a person and said that I was going to color her picture. Also, if I stopped coloring for a moment, she grabbed my hand and moved it back and forth. In a way, she was insisting that we do it together.

I learned that although some students appear to tune out everything and everyone in their environment, they are really totally aware of what's happening.

I learned that whenever a child screams and disrupts the classroom, that you need to tend to them immediately. I was told by my TSS that patience is the key with this sort of child. You need to let this child work through his tantrum and redirect him.

I learned that you can only ignore certain behavior when a child is acting out. After you remove the child and he starts to do the same things, you should correct him and let him know that you will not put up with those type of actions.

I learned when a child starts to kick and scream and throw all of their body weight around, you need to hold the child's arms and legs so that they will not hurt themselves or anyone else.

I learned when a child goes around the room calling his peers and teachers name phrases, you must let that child know that that type of language is not permitted in the classroom.

I learned how to care for special needs children. I learned how different people handle same things differently.

I learned how different everyone can be in their teaching techniques.

I learned that patience is the key to many problems.

I learned that you must have eyes in the back of your head when working with children, and you must have patience.

I learned, as adults, we must model appropriate behavior and manners to young children. They look at us as a role model to follow. Children look up to us.

I learned you must remain calm when children get into aggressive behaviors. One particular child seemed to enjoy and feed on our anger if we displayed it to them.

I learned that exposing children to various types of music, such as classical music, can have a soothing effect on their behavior. I believe children should be exposed to different kinds of music.

I learned how much children love to be rewarded for good behavior. The children become eager to fill the sticker chart up.

I learned to remain calm, take a deep breath and relax. You encounter many stressful, teeth grinding situations with children everyday. Step back and walk away for a couple of seconds before you jump into a stressful event.

I learned that I really enjoy working with children. I can't wait until I student teach.

I learned you must keep a careful eye on children. Some can be quite sneaky at times.

I learned that you must be a caring and understanding individual to work with children. Children value the attention we give to them. They seek it.

I learned that if you are going to restrain, you must know what you are doing. Not just for safety reasons, but to show the child you have complete control of the situation. Never let the child think you are unsure of yourself.

I learned to always know what is going on at all times. These children are to be monitored for behavior problems, but do not over monitor them.

I learned to act confident at all times.

I learned that touching the children is okay and that restraining is not a power tool but an affective calming tool.

I learned that redirecting a child can be very effective as long as it is done properly.

I learned that the class is a class regardless of age. Everyone must follow all the rules at all times.

I learned that one-on-one is really the way to go with children that have behavior problems.

I learned that sometimes letting the child cry and thrash his arms, as long as no one is going to get hurt, is what he needs to do to get his anger out.

I learned to follow my instincts.

I learned everyone approaches things differently but a little help from someone with an open mind can go a long way.

I learned that when working with kids, it is important to be as reliable and as consistent as possible. They need those qualities the most.

I learned that sometimes you think of things you could never see yourself doing but find that they work the best.

I learned that the children that require the most time and effort, are the ones that will give you greatest reward. I also learned that I had touched the other children in the classroom without even knowing it. I also learned, that these children can be so loving and giving, all they want is someone to pay attention to them and to care about them.

I learned that a minor incident can easily escalate into a major event.

I learned that timeout may not always work.

I learned that it is important to be patient while trying to change behavior, it may take a long time.

I learned that it is important to give clear, concise instructions to children.

I learned that it is better to direct comments to a specific behavior so that the child feels in control of or responsible for their own behavior.

I learned that it is important to quickly restrain a child that is exhibiting behavior, ie spitting, throwing furniture, kicking and hitting, for the protection of everyone in the classroom, including the child.

I learned that teachers often have a difficult time allocating their attention to every child. The child who is misbehaving is often the child who gets most of the attention, even if it is negative. When there are one or two children in the classroom that are disruptive, it really takes a lot of time on the teacher's part to manage the behavior and detracts from the time spent positively with other students.

I learned that it is important to help students to develop life skills by actually being allowed to do things themselves.

I learned that it is important to carry through with consequences and be consistent (if you say you're going to do something, do it). In order to change behavior, children need to know that there are certain consequences for their choices and that they are responsible for their behavior.

I learned that children with behavioral disorders can be sweet as anything one minute, and the next be completely out of control.

I learned that I can't control behavior in children. I thought I could change my particular student, but I now realize that he had to learn to want to control his own behavior.

I learned that children with behavior disorders feed off of one another. When one misbehaves, often times the other child will misbehave also.

I learned that children with behavior disorders may be smarter than you think. One particular boy, when introduced to a new TSS, started to test her. He wanted to find out how serious she was. He is only five but, he has a mind of a twenty-five year old.

I learned that as a teacher, you can acknowledge holidays, but must be aware of students who are not prepared to participate. Children become very upset when this happens.

I learned that you must be consistent with all of your students.

I learned that some parents believe they are doing what is right, and they are not willing to change.

I learned that it is very hard to prove that a child is being abused.

I learned that you can stop a behavior by quietly letting the child know he should settle down, not making a big deal out of it.

I learned that students not only need discipline, but they also need to understand what they did and why it was wrong.

I learned to encourage the students to explain their problems with their words, not crying.

I learned that children need time to calm down and get control of their emotions.

I learned that you need to always be aware of what the students are doing.

I learned that children have mood changes and some days are more difficult than others.

I learned that if you use timeouts, you must stay with it until the student sits quietly.

I learned that the student's home life is sometimes bad.

I learned that children need to go outside, run around and just blow off steam.

I learned that children are affected by events in their lives.

I learned that you have to be patient and calm while working with students with behavior problems.

I learned that with constant support and encouragement, to keep a child on a particular task, the work would eventually be completed.

I learned that with a teacher's flexibility and open mind, the program runs more smoothly.

I learned that being at eye level with a child and staying calm has quicker results than yelling.

I learned that if there is less time wasted, there will be fewer problems.

VIII. Recommendations:

1. The TSS's and the interns should be given more designated time to interact.
2. The role of the intern and the TSS should be more clearly defined. During fall, 1996 and spring, 1997, each TSS and intern made their own procedures, and it was a first time experience for both.
3. A better balance is needed in our training sessions, which were somewhat heavier on the cognitive knowledge base for the TSS's than on the classroom uses of TSS's and behavior modification.
4. Evaluation should be improved so that hard data can be obtained relative to what interns actually learned in terms of content and vocabulary.
5. Because of lateness of funding approval, recruiting interns is difficult for the fall semester.

VIII. Appendices:

A. Program Evaluation:

Student Evaluation of the Project:

Student evaluation of the project consisted of a pre and post self-assessment, an opinionnaire related to the project's effectiveness, recommendations for improving the project, and a content-specific questionnaire.

Pre and Post Self Assessment:

All of the interns (students, project participants) indicated substantial improvement regarding project objectives on the pre-post self assessment. The instrument contains fifteen descriptor items.

Two students noted growth on relevant items; four students noted growth on nine items, two students noted growth on eight items; four student noted growth on seven items; the remainder noted growth on fewer than seven descriptors, the lowest being three. The fact that some students noted growth on only three items in attributed to situations where students entered the project with more knowledge of behavioral support programs than others. This wide range of pre-post "scores" also indicates that the instrument "discriminated" regarding the amount of knowledge each participant brought to the project. As will be discussed later, all participants improved their knowledge and understanding substantially, but some improved more than others because some began with a greater knowledge base.

Opinionnaire Related to the Project's Effectiveness:

Information related to the project's effectiveness was measured by a five item questionnaire that asked participants/students to express their feelings. Overall, participants expressed very positive feelings about the project. Only three students expressed any negative feelings, and these "negatives" were only on selected items; they were not negative "across the board." Two students reported concern about the amount of time spent in training, and two students expressed concern about the quality of the training sessions. Only one student expressed the opinion that, overall, the program was "poor." For obvious reasons, these numbers are not considered substantial. However, under other circumstances, these students should be interviewed for "specifics." It should be noted that the vast majority expressed positive opinions regarding the amount of training time, the quality of the training sessions, and the overall evaluation of the program. The participants unanimously reported positive opinions regarding their relationships with their mentors and the information provided by the Human Services Agency.

Recommendations for Improving the Project:

1. The TSS's and the interns should be given more designated time to interact.
2. The role of the intern and the TSS should be more clearly defined. During fall, 1996 and spring, 1997, each TSS and intern made their own procedures, and it was a first time experience for both.
3. A better balance is needed in our training sessions, which were somewhat heavier on the cognitive knowledge base for the TSS's than on the classroom uses of TSS's and behavior modification.
4. Evaluation should be improved so that hard data can be obtained relative to what interns actually learned in terms of content and vocabulary.
5. Because of lateness of funding approval, recruiting interns is difficult for the fall semester.

Content-Specific Questionnaire:

Content-specific growth was measured by a ten item questionnaire that required participants to respond with specific-answers to behavioral-support related questions. For example: Explain the difference between a diagnosis of L.D. and a diagnosis of A.D.H.D. All of the participants responded to each item, however, some responded more thoroughly and more accurately than others. Upon reflection, the questionnaire was very difficult. It did, however, "discriminate" well. None of the participants failed to respond in a manner that indicated some understanding. About sixty percent responded in a manner that indicated thorough knowledge. In retrospect, it appears that one-hundred percent accurate responses could probably only be expected of full-time people in the behavioral support profession. Future content-specific items should be limited to only the most important facts-- those which are reinforced frequently.

B. Pretest Questionnaire:

Check the appropriate descriptor:

		Yes	No	N/A
1.	Do you have knowledge of informal assessment techniques?	____	____	____
2.	Do you have knowledge of scope and sequence of academic content area?	____	____	____
3.	Do you have observation skills?	____	____	____
4.	Do you understand the project's philosophy?	____	____	____
5.	Do you have knowledge of various project goals?	____	____	____
6.	Do you have knowledge of the various instructional strategies?	____	____	____
7.	Do you have knowledge of behavior change strategies?	____	____	____
8.	Do you have knowledge of available resources?	____	____	____
9.	Do you have knowledge of eligibility criteria for student (not intern) placement in this project?	____	____	____
10.	Do you have good listening skills?	____	____	____
11.	Do you have conflict-resolution skills?	____	____	____
12.	Do you possess collaborative decision-making skills?	____	____	____
13.	Do you have knowledge of group dynamics?	____	____	____
14.	Do you have sending and receiving communication skills?	____	____	____
15.	Do the project co-directors have leadership skills?	____	____	____

Source: Adapted from Ohio Department of Education, 1985

C. Posttest Questionnaire:

Check the appropriate descriptor:

		Yes	No	N/A
1.	Do you have knowledge of informal assessment techniques?	____	____	____
2.	Do you have knowledge of scope and sequence of academic content area?	____	____	____
3.	Do you have observation skills?	____	____	____
4.	Do you understand the project's philosophy?	____	____	____
5.	Do you have knowledge of various project goals?	____	____	____
6.	Do you have knowledge of the various instructional strategies?	____	____	____
7.	Do you have knowledge of behavior change strategies?	____	____	____
8.	Do you have knowledge of available resources?	____	____	____
9.	Do you have knowledge of eligibility criteria for student (not intern) placement in this project?	____	____	____
10.	Do you have good listening skills?	____	____	____
11.	Do you have conflict-resolution skills?	____	____	____
12.	Do you possess collaborative decision-making skills?	____	____	____
13.	Do you have knowledge of group dynamics?	____	____	____
14.	Do you have sending and receiving communication skills?	____	____	____
15.	Do the project co-directors have leadership skills?	____	____	____

Source: Adapted from Ohio Department of Education, 1985.

Behavioral Support

D.

Content-Specific Questionnaire

1. How does a student become eligible for Chapter 15 services?

2. List the important features of a Behavior Management Plan.

3. Explain the dirrerence between a diagnosis of S.E. D. And a diagnosis of A.D.H.D.

4. a) Explain the difference of a diagnosis of L.D. and a diagnosis of A.D.H.D.

   b) In what ways are the characteristics of L.D. and A.D.H.D. similar?

5. Explain "self-monitoring" techniques.

6. In terms of behavioral characteristics, what does the term "antecedents" refer to?

7. Explain four guidleines to keep in mind when modifying curriculum for the A.D.H.D. child.

8. List five characteristics of a well-managed and organized classroom.

9. List five guiding principles for raising a child with A.D.H.D.

10. List four deficits experienced by A.D.H.D. children.

E. Oral Debriefing Report:

Questions:

1. What did you enjoy about the Behavioral Support Project?
2. What did you learn about yourself when working in this project?
3. What did you learn about others while working in this project?
4. What one event do you specifically remember?
5. What patterns are forming from your experience?
6. Cite three skills you learned that will help you while working with children.
7. What comments do you have about the project?

Answers to above questions (in number order):

1: Question: What did you enjoy about the Behavioral Support Project?

I really enjoyed working with the children. I found the experience of working with problem children terrific!

I enjoyed the experience and the knowledge I was able to collect over the last several months.

I enjoyed teaming with my TSS and experiencing a Head Start environment.

Seeing different teaching styles, and I enjoyed building relationships with the children and learning how to deal with their emotions.

That we have hands-on experience with TSS, students, and teachers.

Being with the children and learning how to work with children who can be very frustrating to teachers. Learning how other teachers work in the classroom was beneficial.

I enjoyed working with the two children. I had first-hand experience in a life skills classroom.

It was a wonderful experience that will prepare me for behavior disorders in the classroom.

I enjoyed working with the kids.

I enjoyed all of the one-on-one experiences.

2. Question: What did you learn about yourself when working in this project?

I learned about some of the hard home lives some of these children have. I learned that you should be very caring and understanding to children.

I learned I had a lot to learn. I never realized how bad some kids have it at home.

I learned that I can separate my personal biases (family grouping, etc.) from my professional attitude.

I learned I need to be more patient and firmer when giving directions.

I learned that I have to monitor myself in certain situations, such as giving enough positive praise. Monitor my anger. And, how much I really know about responsible behavior.

I learned that I needed to stop looking at the negative outcomes of the child and start looking for more positive things.

I learned that one of my biggest problems is disciplining a child. I find it hard to tell a student "no." I also have to consciously think about following through on what I say.

I learned that I have to be more patient.

I learned that I'm a little shy around new people and situations.

I learned that I have a lot of knowledge inside of me that I need to tap in on.

3. Question: What did you learn about yourself when working in this project?

I learned cooperation, and what the role of the TSS plays compared to the teacher.

I learned there are some great teachers who are willing to do whatever it takes to help the children.

I learned that the staff of the Head Start Program did a lot of work with very little respect.

I learned that everyone doesn't think the same way I do. That everyone has different styles and we need to work together to accomplish goals.

I learned that each person has a responsibility in doing their job, what TSS stands for, what a TSS does, and how others deal with behavior.

I learned that everyone is unsure of how to look at you until you speak up and ask questions about how they handle their class and what your role is.

I learned that teachers' attitudes play a huge part in how the class will be run.

I learned how different others' childhoods are than mine.

I learned everybody has different techniques and things that can and do work with different children.

I learned people grow together, not just the children but the adults as well.

4. Question: What one event do you specifically remember?

I remember when the one child came to me instead of the TSS for something.

I remember the day my child came in with tattoos all over his body. The one on his chest read "eat shit." It was at this time that I began to see what kind of life he had.

I remember the day that a child in the program screamed, kicked our furniture, spit, and tried to hit the TSS.

I remember when my student said my name for the first time ----- I made an impact!

I remember when the student I was working with came and sat on my lap when the teacher was reading a book. I felt that the student and I made a connection.

I remember when I was called over to my one boy and he told me when he grew up he wanted to be "white." That stumped me.

The one event I remember most is when the one little boy was having a difficult time keeping his hands and feet to himself and for the first time responded to me when I intervened.

I remember finding out about my child's home situation from him.

I remember giving "Brett" the watch at the end of the internship and him saying that he is going to be bad, "So I stay."

5. Question: What patterns are forming from your experience?

I believe you should greet all children. If the children are eating, sit down, and eat with them.

I see children caught between two worlds. One world is at school where they have rules and support. The other is at home, where they do not get support and there are no rules.

I learned that it is important to be consistent with behavioral management and children in general.

I learned children get tired in the afternoon and need more activities. They need to move and not sit in their seats.

I learned that many behaviors keep forming over and over.

I learned to look at all children in the same eyes.

I learned that he children looked to me and the TSS for help.

I learned that in each experience one-on-one discussions are the best.

I learned that certain kids tend to set him off.

I learned to be more aware and not to jump to my first approach, but to sit back a little longer and watch.

6. Question: Cite three skills you learned that will help you while working with children?

Patience, understanding, confidence.

Patience, techniques for dealing with children, teaching strategies and ideas.

I learned to team. Several types of behavioral modification. Several classroom techniques.

Understanding, patience, sensitivity.

One-on-one communication, patience, working with other professionals and listening.

Eye level!! Patience! Understanding.

Not to jump on every little thing children do wrong. Patience is needed when working with children. There is no one right way to get to a specific goal.

Patience, understanding my child's disorder and learning how to relate to him.

Time-out technique, cues to look for in the child and activities to do in my classroom.

More patience, the correct way to do a timeout, redirecting skills.

7. Question. What comments do you have about the project?

I believe the project was very beneficial for me. I learned a lot about children.

This was a positive experience for me. The TSS that I worked with was great to work with. I do think that the program TSS's need more training to help their skill level and confidence.

TSS's need to be consistent in their approaches and they need to be committed to the project and the child. When problems arise with placement, options need to be available.

This project is not only good for special education, but regular education also. The TSS along with HSC was very helpful and were great people to work with. Along with the supervising professors, I owe a great deal to HSC and the TSS's for continuing my education in education.

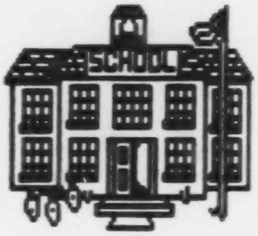
It was a good experience at times and I would recommend it to others.

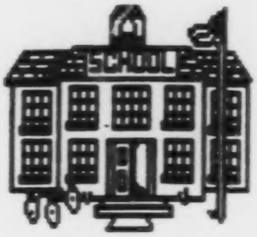
I saw this internship as a wake up call as to what is going on in classrooms and the problems that so many children face on a day-to-day basis.

It was a wonderful experience that I would recommend to everyone planning to be a teacher.

I thought this was a great experience and opportunity for employment. I have a job after I graduate.

I would have like to have more training. The rest of the internship was very rewarding.

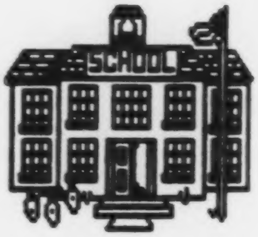


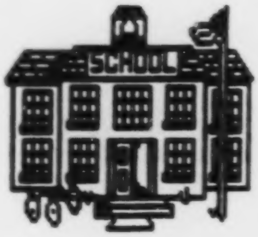


Internship in Education

BEHAVIORAL SUPPORT PROJECT
(79.312 -- 3 CREDITS)

DR. VIOLA SUPON
DR. BONNIE WILLIAMS
DR. ROBERT CLARKE





BLOOMSBURG UNIVERSITY

F

Course Syllabus

Department: Curriculum & Foundations

Date Prepared: Fall, 1996

Course Title: Internship in Education 79.312
* THE BEHAVIORAL SUPPORT PROJECT *

Credit Hours: 120 hours - 90 hours field work; 30 hours seminars

Prerequisites: Junior standing and a cumulative grade point average of 2.5

Catalog Description: A work study program in an education-related setting applicable to fulfilling professional elective requirements in teacher education degree programs.

Goals: As noted in the University Bulletin a specific aim of teacher education programs is to help students acquire a depth and breadth of knowledge in both general and specialized studies. Therefore, the principal goal of an Internship in Education with The Behavioral Support Project is to prepare preservice teachers in the theory and application of behavioral intervention and support strategies under the guidance of certified behavioral specialists and a clinical psychologist. The preservice students will work with children with behavioral disorders in inclusive classrooms.

Objectives: The objectives for the internship will be individualized and jointly developed by the faculty supervising the experience and the organization to which the student is assigned. A major criterion for the internship must be its relevance to the student's certification area, of equal importance will be the compatibility of the student's skills, abilities, or needs with those demanded by the placement.

Content Outline: Because of the individualized nature of the internships, learning and experiences will have similarities, yet vary in accordance with declared goals and objectives. (See above).

Methodology:

1. Faculty supervisor or student contacts cooperating agency or individual to establish objectives as well as duties and responsibilities of the student.
2. Student and faculty supervisor meet to discuss objectives, responsibilities, expectations and evaluative procedures. (An on-site visit of the placement by the student is recommended.)
3. When the parties involved agree that an internship shall occur, a form of agreement will be signed by the participants. Included should be relevant dates, hours, objectives, methods of evaluation and any other appropriate information.

Evaluation Procedures:

1. The student will submit a log/diary of all internship activities as well as a final paper addressing the achievement of the internship's objectives and any new insights or learning that has been gained.
2. Regular student/advisor office or telephone conferences will be conducted that accommodate the schedules of both parties.
3. On-site visit(s) and/or telephone calls to the cooperating individual or agency will be made by the University Supervisor. At least one on-site visit is recommended.
4. A written summative evaluation of the student's internship experience (a narrative description or the standard form/checklist) will be submitted by the cooperating individual or agency.
5. A final student/supervisor conference may be held to discuss the evaluation.
6. The granting of a final grade will be the responsibility of the faculty/supervisor.

Recommendation: The student should arrange for liability insurance for the duration of the internship. (see the University Supervisor).

*The nature of the work assignment will determine the credit hour total in specific cases.

BLOOMSBURG UNIVERSITY
BLOOMSBURG, PA
DEPARTMENT OF CURRICULUM AND FOUNDATIONS
EVALUATION OF STUDENT INTERNSHIP IN EDUCATION

NAME OF INTERN ______________________________
INTERNSHIP SITE ______________________________
INTERNSHIP DATES FROM ______________ TO ______________
COOPERATING SUPERVISOR ______________________________

Place a checkmark under the heading that best describes the student's characteristics, abilities and / or performance in each of the following. Please think of each item as discrete entities to be evaluated separately.

	EXCELLENT	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE	UNSATISFACTORY	NOT APPLICABLE
I. PERSONAL QUALITIES						
A. Appearance						
B. Vitality and Energy						
C. Responsibility						
D. Enthusiasm						
E. Positive Attitude						
F. Responsive to criticism						
G. Leadership potential						
II. Assessment Ability						
A. Ability to identify/grasp problems or tasks						
B. Ability to collect data to solve problems						
III. Planning Ability						
A. Effectively plans to meet problems or tasks						
B. Effectively plans to meet long-range goals						
C. Plans creatively or inventively						
D. Keynoted of planned activities						
E. Quality of planned activities						
F. Plans for self-development						

	EXCELLENT	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE	UNSATISFACTORY	NOT APPLICABLE
IV. Executive Ability						
A. Execute plans effectively						
B. Modifies execution of plans based on feedback						
V. Communication Abilities						
A. Oral communication						
B. Written communication						
C. Non-Verbal communication						
D. Inter-personal relationships						
VI. Management Abilities						
A. Manages time effectively						
B. Manages materials or equipment or the environment effectively						
C. Manages routine activities effectively						
VII. Evaluation Abilities						
A. Maintains necessary records						
B. Evaluates data for planning						
C. Evaluates others						
D. Evaluates self						
IX. Professional Potential						

X. Concluding Remarks (optional)

WHAT IS BEHAVIOR MANAGEMENT?

Behavior management is the process of maintaining appropriate student behaviors through a variety of approaches. It is assumed that all approaches will be used fairly and ethically. All students must be treated with the same respect demanded of them. The primary responsibility of the professional working with the student who has emotional handicaps is to provide a structured, organized, positive environment conducive to teaching appropriate behaviors and replacing existing inappropriate ones. It is important to use the same strategies consistent with the overall behavior management plan. Lack of consistency increases the probability that the student will continue to exhibit the problematic behaviors.

The following wide range of behaviors frequently observed in students indicate those for which the counselor may need to respond:

NON-COMPLIANCE -- Refusing to:
- follow directions
- remain in assigned seat
- stay on task
- accept authority

PHYSICAL AGGRESSION
- kicking
- hitting
- biting
- spitting
- throwing things
- destruction of property
- self-abusive behaviors

VERBAL AGGRESSION
- swearing
- verbal threats
- name calling

ATTENTION SEEKING BEHAVIORS
- excessive talking out
- obscene gestures
- inappropriate facial expressions
- unnecessary questions
- inappropriate noises
- power struggles (peers/adults)

REFUSING TO ACCEPT RESPONSIBILITY
- lying
- cheating
- denial
- shifting blame

INADEQUATE SOCIAL SKILLS
- stealing
- inability to cope with conflict
- manipulation
- hostility
- insecure relationship with others

. Indiana State Department of Education. (1987). Counselor's Resource Guide for Supporting Programs for Emotionally Handicapped Students. ERIC Reproduction Service, 303959.

STRATEGIES:

Classroom

Curriculum

Behavior Management

Support Services (include school, family, community)

Indiana State Department of Education. (1987). *Counselor's Resource Guide for Supporting Programs for Emotionally Handicapped Students.* ERIC Reproduction Service, 303959.

JOURNAL CATEGORIES

- Teachers Helping Their Students
- Behavioral Problems
  - *Stress-related, antisocial behaviors, social-skills deficit, self-management problems)
- Techniques to Modify Behavior
- Techniques to Increase Social Competence
- Techniques to Improve Academic Performance
- Resolving Resistance
- Parental/Guardian Support
- Legal and Ethical Concerns
- Assessment as an Integral Part
- Strategies for Program Effectiveness
- Consultants/University Support
- Integration of Resources
- Future Directions for Program

DAILY JOURNAL FORMAT

"Because a lesson seems unproblematic, even uneventful, it does not mean there is nothing to observe. The essence of observation is the creation of insight out of what might seem initially to be routine and commonplace. Hidden beneath the surface of this lesson are unresolved issues which, when they are made visible, reveal possible alternative beliefs, values, and practice."
Source: Walker, R., & Aldeman, C. (1975). A guide to classroom observation (p. 18), London: Methuen.

……

Using a separate sheet for each day, recall one incident that was significant to you. What do you think you learned from it? Make certain to date each entry.

In two sentences, cite the incident. Skip a line. Then begin the next line with "I learned".......and do a simple analysis of this incident.

DATE ____________________

INCIDENT:____

____

____

____

____

____

____

BEST COPY AVAILABLE

SPECIAL ASSIGNMENT

Each intern will select a different aspect of behavioral support. You are to gather 6 articles from DIFFERENT educational journals (within the past three (3) years). Highlight six new insights from each article. Then take one statement from each article that is most impacting. On a separate sheet of paper (IN TYPEWRITTEN FORMAT), CITE THE NAME OF YOUR TOPIC AND THEN LIST SIX OF THE MOST PROFOUND STATEMENTS ABOUT THIS ASPECT. BE CERTAIN THAT EACH ENTRY IF REFERENCED PROPERLY USING THE APA (AMERICAN PSYCHOLOGICAL ASSOCIATION) STYLE OF DOCUMENTATION. Be certain to cite the statement and author/s together. Check with the library so you have it correct. There are different styles and only the APA will be accepted.

G. Internship Time Sheet:

Human Services Consultants
Bloomsburg Project

Intern Name: ______________________ Period From ________ To ________

Program Location: ______________________ SS# ________________

Week One

Day	Date	Time In	Time Out	Regular Hours				Total Hours
Saturday		_m	_m					
Sunday		_m	_m					
Monday		_m	_m					
Tuesday		_m	_m					
Wednesday		_m	_m					
Thursday		_m	_m					
Friday		_m	_m					
Total								

Week Two

Day	Date	Time In	Time Out	Regular Hours				Total Hours
Saturday		_m	_m					
Sunday		_m	_m					
Monday		_m	_m					
Tuesday		_m	_m					
Wednesday		_m	_m					
Thursday		_m	_m					
Friday		_m	_m					
Total								

nternship Signature: ______________________ Date: ________

S Manager ______________________ Date: ________

Supervisor ______________________ Date: ________

For Office Use Only

Regular Hours					
Total Hours					

H

I would like to use the video tapes of your teaching in training undergraduate/graduate students/teachers in observation/conferences skills, in workshops, demonstrations, speaking engagements, and/or in interviewing potential applicants for positions in education. Viewing real situations will be of great value in training. It will further help me evaluate the administrative and supervision competencies, strengths, and weaknesses of the educators watching a teaching/learning situation. Your name will not be used.

I would like to use information elicited from written materials, assignments, or projects you completed during your student teaching assignment for the purpose of writing articles, books and/or use in speeches, seminars, workshops, in-service programs, staff development, or other educational projects.

Please read the paragraph below, affix your signature, date both copies, keep one copy and return one copy to me.

I, the undersigned, hereby grant Viola Supon, Robert Clarke, Bonnie Williams and her authorized representatives the right to make a copy of and use my teaching video tape, written materials, projects, or assignments in any manner she deems appropriate. Viola Supon, Robert Clarke, Bonnie Williams retains the right to edit this tape/other materials as Viola Supon, Robert Clarke, Bonnie Williams deems appropriate.

It is my understanding that I will receive no compensation, royalties, advances, or other payments from Viola Supon, Robert Clarke, Bonnie Williams or her agents, now or in the future. The teaching video I have contributed is my original work and is not bound or owned by anyone except me. The teaching video and all other materials I have provided is given freely. I have read, understand, and hereby, agree to the above agreement.

SIGNATURE: ______________________________

DATE: ______________________________

(PLEASE RETAIN ONE COPY FOR YOUR RECORDS)

I. Resources

American Public Welfare Association
810 First Street, N.E.
Suite 500
Washington, DC 20002-4267

Aspen Publishing, Inc.
1600 Research Blvd.
Rockville, MD 20850

Association of Retarded Citizens
500 E. Border Street
Arlington, TX 76010

Association for Supervision and
Curriculum Development
1250 N. Pitt Street
Alexandria, VA 22314

Association of Birth Defect Children
Orlando Executive Park
5400 Diplomat circle, Suite 270
Orlando, FL 32810

Biodot International, Inc.
P.O. Box 46229
Indianapolis, IN 46229

Center for Applied Psychology, Inc.
Childswork/Childsplay
P.O. Box 61586
King of Prussia, PA 19406

Children with Attention Deficit Disorders
(CHADD)
499 70th Avenue, N.W.
Suite 109
Plantation, FL 33117

Clearinghouse on Disability Information
Office of Special Education and
Rehabilitation Services
U.S. Department of Education
Switzer Building, Room 3132
Washington, DC 20202-2524

Council for Exceptional Children
1920 Association Drive
Reston, VA 22091

Council for Learning Disabilities
P.O. Box 40303
Overland Park, KS 66204

Federation for Students with Special
Needs
95 Berkley, Suite 104
Boston, MA 02116

Institute for Rational Emotive Therapy
45 East 65th Street
New York, NY 10021-6593

Judge David L. Brazeton Center for
Mental Health Law
1101 15th Street, N.W.
Suite 1212
Washington, DC 20005

Learning Disabilities Association of
America
4156 Library Road
Pittsburgh, PA 15234

National Association of Social Workers
750 First Street, N.E.
Washington, DC 20002

Resources (continued):

National Center for Learning Disabilities
381 Park Avenue South
Suite 1420
New York, NY 10016

National Down Syndrome Society
666 Broadway
New York, NY 10012

National Education Association
1210 16th Street, N.W.
Washington, DC 20036

National Information Center for Children & Youth with Disabilities
P. O. Box 1492
Washington, DC 20013-1492

National Mental Health Association Federation of Families for Children's Mental Health
1021 Prince Street
Alexandria, VA 22314-2971

Orton Dyslexia Society
Chester Bldg.., Suite 382
8600 LaSalle Road
Baltimore, MD 21286-2044

PRO-ED, Inc.
8700 Shoal Creek Road
Austin, TX 78757

Research Press
2612 Mattis Avenue
Champlain, IL 61820

Timberline Press
Box 70071
Eugene, OR 97401

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